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COVERAGE OF PSYCHOLOGISTS' SERVICES UNDER THE MEDICARE PROGRAM, INCLUDING H.R. 774

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED FIRST CONGRESS

FIRST SESSION

MARCH 6, 1989

Serial 101-23

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COVERAGE OF PSYCHOLOGISTS' SERVICES UNDER THE MEDICARE PROGRAM, INCLUDING H.R. 774

MONDAY, MARCH 6, 1989

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, D.C.

The subcommittee met, pursuant to call, at 1 p.m., in room 1100, Longworth House Office Building, Hon. Fortney Pete Stark (chairman of the subcommittee) presiding.

[The press release announcing the hearing follows:]

FOR IMMEDIATE RELEASE
WEDNESDAY, FEBRUARY 22, 1989

PRESS RELEASE #3
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
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THE HONORABLE FORTNEY PETE STARK (D., CALIF.), CHAIRMAN,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES,
ANNOUNCES A HEARING ON
ISSUES RELATED TO COVERAGE OF PSYCHOLOGISTS' SERVICES
UNDER THE MEDICARE PROGRAM, INCLUDING H.R. 774,
TO BE HELD ON MONDAY, MARCH 6, 1989

The Honorable Fortney Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, today announced that the Subcommittee will hold a hearing on issues related to the coverage of psychologists' services under the Medicare program, including H.R. 774. The hearing will be held on Monday, March 6, 1989, beginning at 1:00 p.m., in the Main Committee hearing room, 1100 Longworth House Office Building.

Oral testimony will be heard from invited witnesses only. However, any individual or organization may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND

With certain exceptions, Medicare coverage of outpatient mental health services is limited to services provided by physicians. Generally, these services are provided by psychiatrists.

Mental health services are also provided by psychologists, who are Ph.D.-trained mental health professionals. Psychologists are licensed for independent practice in all fifty States and in the District of Columbia. Many private insurance plans cover services provided by psychologists. However, under current law, psychologists' services are covered by Medicare only if provided in a community mental health center or rural health clinic.

On February 2 of this year, The Honorable William J. Coyne, (D., Pa.), a Member of the Subcommittee on Health, introduced a bill, H.R. 774, which would extend Medicare coverage to services provided by psychologists effective January 1, 1990.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

For those who wish to file a written statement for the printed record of the hearing, six (6) copies are required and must be submitted by the close of business on Friday, March, 24, 1989, to Robert J. Leonard, Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. An additional supply of statements may be furnished for distribution to the press and public if supplied to the office of the Subcommittee on health, 1114 Longworth House Office Building, before the hearing begins.

(MORE)

SEE FORMATTING REQUIREMENTS BELOW:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will **not** be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages.
2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.
3. Statements must contain the name and capacity in which the witness will appear or, for written comments, the name and capacity of the person submitting the statement, as well as any clients or persons, or any organization for whom the witness appears or for whom the statement is submitted.
4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and public during the course of a public hearing, may be submitted in other forms.

* * * * *

Chairman STARK. The Subcommittee on Health will begin today's hearing, which has been scheduled to consider H.R. 774, introduced last month by my colleague, Mr. Coyne, whom the weather has made a little tardy.

H.R. 774 would provide Medicare coverage for psychologists' services. Under current law, coverage for these services is sharply limited.

The hearing will also focus on problems related to the treatment of nursing home patients suffering from mental disorders.

This prevalence of mental disorders in the elderly is well documented. Purely psychological problems, such as depression, grief or loneliness, are often compounded by organic disorders, such as Alzheimer's disease.

Numerous studies show that the elderly often fail to receive optimal treatment for these conditions. Even more disturbing is the fact that inadequate diagnosis and treatment often lead to the unnecessary institutionalization of a senior citizen who could otherwise remain in the community closer to family and friends.

One shortcoming of the current Medicare program may be contributing to these problems. With certain narrow exceptions, Medicare does not pay for services provided by psychologists. Psychologists could play a more active role in providing care to our elderly and disabled if this restrictive policy were amended.

This is the issue that Mr. Coyne has asked us to address. It is my expectation that the subcommittee will consider Mr. Coyne's proposal and relevant alternatives seriously over the next several months. What Medicare beneficiaries with mental disorders need is a team approach by mental health professionals who are well trained, concerned and dedicated to the care of their patients.

Our second focus today relates to the special problems of nursing home patients with mental disorders, particularly problems related to the inappropriate use of psychoactive medications. We will hear about the extent of these problems and the need for possible corrective action.

Our first witness will be Senator Jay Rockefeller, the chairman of the Subcommittee on Medicare and Long-Term Care of the Senate Finance Committee and the author of the Senate counterpart to H.R. 774.

I might add, before I recognize other Members for their statements, that one of the great concerns the chairman has in this is why people with a master's in social work were inadvertently left out of the psychologists' bill, seeing that that is what my daughter is currently studying, and I cannot afford to keep her in for a Ph.D. I would like some of the witnesses to comment on why her field is left out.

I would like to include Mr. Coyne's opening statement in the record at this time.

[The statement of Mr. Coyne follows:]

OPENING STATEMENT
March 6, 1989
Hearing on Medicare payment of psychologists

It is my pleasure to be here today to discuss H.R. 774, a bill I introduced in early February with 40 of my colleagues. This bill would provide direct reimbursement for psychologists under Medicare.

I support the expansion of Medicare coverage so as to include psychologists for numerous reasons. The first and the most compelling one is to expand mental health benefits for senior citizens.

Currently, Medicare allows reimbursement for mental health care to psychiatrists. Psychologists are reimbursed only in limited situations, specifically, when care is provided in a community mental health center and rural health clinic. Yet, the reality is that two-thirds of the Nation's counties lack psychiatrists. Many of these areas do have psychologists; but the present limitations under Medicare serve as an impediment to those patients who need the services of a mental health provider. Just last week I received a letter illustrating this problem. The letter concerned an 84 year old woman who was troubled and depressed over a family problem. Furthermore, she was anxious and fearful that she was losing her memory. She went to a psychologist who had treated other family members in the past and who was within walking distance of her home. However, Medicare would not allow payment for services to help this woman. This is not an unusual tale.

We face the continuing challenge of encouraging qualified health-care professionals to serve in rural and underserved areas. Yet, many psychologists are already established and licensed to provide mental health care in these communities. It is ironic that we would craft incentives to keep them practicing yet we choose not to reimburse them under Medicare for their services.

H.R. 774 has solid precedent. CHAMPUS and FEHBP (Federal Employee Health Benefit Plan), as well as 42 states, recognize that patients should have the freedom to choose either a psychologist or a physician for mental health treatment. Some local community hospitals also acknowledge the services of psychologists by requesting that privileges be extended to them in psychiatry departments. Thus, this bill does not break new ground. Rather it institionalizes freedom of choice for patients and in some cases, gives access to the only qualified provider of mental health treatment that is available.

The revenue estimates for this bill are low. However, given that patients are more likely to select psychologists and that psychologists charge less than physician mental health providers, the long-term effects may well offset any cost to the program.

This bill has received strong support from groups such as National Council of Senior Citizens, National Association of State Mental Health Program Directors, the National Hispanic Council on Aging and others.

I believe it is in the public interest and the best interest of Medicare beneficiaries to follow the example of other federal and private insurance programs and reimburse psychologists for services. HR 774 would serve the needs of this country's aging population, improve access to quality mental health providers and make Medicare more consistent with other carriers.

QUESTIONS FOR PSYCHOLOGISTS

How frequently are you or members of your organization greeted with elderly patients who want care, yet are unable to receive it from you because Medicare does not cover it?

Psychologists, by law, are required to refer a patient to a physician if the patient's problem is suspected to be medical in origin. How would you be able to determine that it is medical and not behavioral?

What actions would be taken against a psychologist who did not properly refer a patient who had a medical disorder and not a mental one?

Psychologists are recognized as providers under CHAMPUS, the Federal Employee Health Benefits Plan and many other private insurance plans. Are there any cases that you know of where a psychologist has not properly referred the patient?

The main purpose of HR 774 is to provide access to quality mental health care to Medicare beneficiaries. Thus, it will increase costs, although very little. Is it possible that it may be more cost shifting than cost increasing? For example, although a patient would seek a psychologist's service, and thus, increase usage of the program, is it possible that it may decrease use of another, more costly, physician's service?

If we include psychologists in the Medicare program, should we open it up to other non-physician health care providers? What criteria should we use to determine providers under the program?

It is estimated that mental health problems are over looked by general practitioners in about 50 percent of elderly patients. Why is that?

QUESTIONS FOR PSYCHIATRISTS

Do psychiatrists and psychologists ever work together? Why is that?

It has been suggested that 65%-85% of the mental health services received come from a general physician rather than a mental health provider. Is there a specific reason behind that? Has your organization ever tried to address this?

Many allege that there is a high percentage of over drugging in the elderly. How are you able to recognize over medication of a patient?

Because of their medical training, psychiatrists are permitted to prescribe drugs. When you determine that a patient requires a prescription drug, do you work in concert with the general physician to avoid over drugging or to make certain that the problems you observe are not drug induced?

You recommend that there be a medical differential diagnosis and a treatment plan by a physician, preferably a psychiatrist, before reimbursement to psychologists for mental health treatment (medical referral). Does that mean that a patient must receive a medical evaluation before seeking any sort of mental health benefits? Doesn't this pose double billing, and thus, added costs to the patient?

The average Medicare beneficiary sees a physician once every five weeks. Why then is a medical referral clause necessary?

HR 774 psychologists are required to accept assignment. Would psychiatrists be willing to accept assignment? Do you now?

QUESTIONS FOR OVER MEDICATING THE ELDERLY IN NURSING HOMES

In how many instances has an institution taken disciplinary action against staff that has over medicated patients? How many instances have state or federal government agencies taken action?

Would you have any recommendations on how physicians and nursing homes that over medicate might be held more accountable under the law for their actions?

What is the composition of medical staff at an average nursing home? How many physicians, nurses, psychologists, social workers, etc. are there? How often do they meet to discuss patient problems?

Should there be one patient care manage in the nursing home environment?

What steps could be taken to change the current structure of incentives to over medicate?

Because the elderly population is increasing, should physicians and other health care providers be required to have more course work in geriatrics? How would you formulate a requirement for improved education of this population?

Are there any current laws that prohibit or discourage you from hiring certain health care personnel? How could this be changed?

Has over medication in nursing homes in other countries?

What alternatives are there to medicating the elderly?

Chairman STARK. Mr. Gradison.

Mr. GRADISON. Thank you, Mr. Chairman.

I am delighted you scheduled the hearing today on this very important subject.

Let me say, I have not been lobbied on this yet by one of my many daughters. As you know, I have seven of them, and one is a clinical social worker with a private practice. I am very interested in this, as well. I look forward to the testimony today.

Thank you, Mr. Chairman.

Chairman STARK. Mr. Levin.

Mr. LEVIN. I have a statement and I will summarize it, in view of the very distinguished persons waiting to testify, and ask that it be entered into the record.

In the statement I review the inadequacy of our mental health coverage today through Medicare. I point out that a number of us last Congress introduced proposals to improve that benefit. Those proposals were adopted in part. The inadequacy, partially and importantly, remains.

Second, it underlines a point you made, Mr. Chairman, about a cooperative approach here. I would hope we might approach this issue with some aura of common purpose.

I do refer in my statement to my own experience going back to the State legislature in Michigan. When dollars are tight, people tend to compete rather than cooperate. I don't say that with any pointed references to any of the witnesses here today, but I think there is a common objective here and we ought to find an answer that people can live with and work together on, instead of perhaps reflectively being in conflict.

Last, Mr. Chairman, I point out that other programs have found a new and cooperative way of handling mental health issues and benefits. I point specifically to CHAMPUS and how they have adopted a system of case management, peer review and utilization and quality assurance. Together I think that adds up to a system that may cost more in the short run and not only provides better care but also will be cheaper, as well as more humane, in the long run.

So I very much look forward, Mr. Chairman, to the testimony here, and I would ask that my entire statement be entered into the record.

Chairman STARK. Without objection, your entire statement will appear in the record.

[The statement of Mr. Levin follows:]

Opening Statement by Congressman Levin
Subcommittee on Health
Hearing on Medicare Mental Health Coverage
March 6, 1989

Mr. Chairman:

I want to commend you for convening this hearing today.

It is so important that the Committee continue its interest in improving Medicare's coverage for mental health services. Our program's coverage and reimbursement policies for mental health services are uniquely outdated. Medicare remains stuck in the 1960s. The existing dollar- and day- and lifetime-limits on care are anachronisms -- established when most mental health care was inpatient and when the professions knew relatively little about how to manage care.

Worse, the various arbitrary limits on care and who can provide it serve to seriously limit the elderly's access to mental health care. We will hear testimony today that 1/2 to 2/3 of the elderly's mental health needs are unmet. That is a discrace.

In the last Congress, I worked with my colleagues Mr. Coyne, Mr. Downey, and others to increase the outpatient mental health benefit from $250 to $1100. That's roughly a 25-year inflation adjustment -- though inflation has already eroded the value of this improvement.

In this Congress, I've cosponsored Mr. Coyne's legislation to reimburse psychologists as a further step toward expanding access to mental health services under Medicare.

We need even more improvement, though. Because Medicare's mental health coverage and reimbursement is so limited, we run the risk of missing the main point today. It has been my experience over the years that when money for a given service is tight, we tend to see more competition among providers for scarce dollars instead of cooperation in assuring quality of care. I don't offer that as a criticism of our witnesses today. Rather, I want to encourage my colleagues on the Committee to take a broader view of the problems we face.

We should be looking at what other programs are doing. CHAMPUS -- another major federal health program -- has replaced many of its arbitrary limits on mental health services in favor of careful case management, peer review, utilization review, and quality assurance.

Why can't we look at these alternatives for our Medicare program? Yes, it will undoubtedly cost more money. But when we pinch pennies on mental health care, as we will hear from our witnesses today, we do so at tremendous cost to the beneficiaries and their families.

Medicare stands out in the poor quality and scope of our mental health coverage. Other private and public health insurance programs are doing much better. I hope, Mr. Chairman, that today's hearing will be followed by another, so that we can examine the innovations that have been incorporated in other programs like CHAMPUS. I hope this Committee will explore comprehensive reform of the Medicare mental health benefits.

Chairman STARK. I am pleased to call on the Honorable John Rockefeller from the State of West Virginia.

First of all, my congratulations on your appointment as subcommittee chair in the Senate Finance Committee. It is a pleasure to have you with us today.

Why don't you proceed in any manner that you are comfortable.

Senator ROCKEFELLER. Thank you, Mr. Chairman. I look forward to working with you on what is for me new responsibilities and what is for you long-time responsibilities.

STATEMENT OF HON. JOHN D. ROCKEFELLER IV, A U.S. SENATOR FROM THE STATE OF WEST VIRGINIA

Senator ROCKEFELLER. I thank you for holding this hearing today. I greatly appreciate the opportunity to testify in support of legislation of considerable importance to the health of the elderly in our country.

I have to say that I think Congressman Coyne is to be commended for his leadership role. I believe that Medicare coverage, Mr. Chairman, of psychologists' services will go a long way towards meeting the elderly's tremendous need for mental health services.

The need for mental health care among the elderly is at least as great as the general population. While nearly 7 million elderly need some type of mental health assistance, only a few are receiving that help—as many as 80 percent are not receiving the care they need.

Without appropriate care, many seniors are forced to live unnecessarily unhappy, confused, or institutionalized lives. A large number of elderly, labeled senile, actually have reversible, treatable conditions and, if appropriately recognized and treated, could continue living independently in the community.

Unfortunately the elderly receive less mental health care than any other age group. There are many reasons why this is so. Many older Americans are reluctant to admit mental health problems—I am not sure that is limited to the elderly, but it is a fact with many of them—and attempt to deal with problems on their own. Frail and homebound seniors, elderly nursing home residents, and older persons with transportation problems have a hard time getting mental health services. Medicare unfortunately contributes to the access problem by failing to reimburse mental health care provided by a psychologist.

In my own State of West Virginia, there is not one psychiatrist practicing in 60 percent of our counties; and 73 percent of our psychiatrists are in only 3 of our 55 counties, which is to say to this Representative of West Virginia that 40 percent of the rural elderly in West Virginia live in areas without a psychiatrist.

I was Governor of my State for 8 years. My State leads the country in plant closings. I am not proud of that, but I had to deal with that. When a coal mine closes, it is not just the coal miner who is hurt, but it is his family, his mother and father. Floods ravage West Virginia many times resulting in tragedies. I know, from my personal experience, that psychologists have been there to reach out and help people when others have not been there.

That is why I feel it is so tremendously important for the Medicare program to catch up with other health insurance program—and, for that matter, State law—and give senior citizens both the choice and the ability to be treated by professionally trained psychologists.

Only highly trained and experienced professionals—mental health professionals that are licensed by their State to diagnose and treat mental disorders—would be able to receive reimbursement by Medicare. If you have a doctorate in psychology, you have finished 7 years of training after college—7 years of training.

Expanding coverage for psychologists' services would undoubtedly improve access to mental health care in a State like West Virginia, and many other States that have regions typically underserved.

This is a beneficiary issue. I feel strongly that Congress has the obligation and the responsibility to make sure that Medicare beneficiaries are able to obtain the vital mental health services to which they are entitled and not be shut out because of where they live.

I don't think geographic discrimination is part of our civil rights laws, but it is part of our health and happiness laws. If you don't live in the right place it is tough on you, and if you are elderly it is terrible.

Seniors want to choose their own health care provider. Expanding Medicare coverage would give seniors the opportunity to choose the mental health provider who is right for them; it gives them freedom of choice.

S. 100—and I am proud of that number—and H.R. 774 would also help seniors with out-of-pocket costs by requiring psychologists to accept assignment. What this means is that a beneficiary would not have to pay for any additional charges above what Medicare determines is a reasonable charge—a safeguard that is extremely important to beneficiaries. Additionally, I believe I am right in saying that psychologists' charges are lower than psychiatrists' charges.

I was glad that 2 years ago, Congress authorized coverage of mental health services provided by psychologists practicing at rural health clinics and community mental health centers. I hope this year we can agree to completely remove an artificial barrier to mental health care for this nation's older Americans by authorizing Medicare reimbursement for psychologists' services.

[The prepared statement of Senator Rockefeller follows:]

STATEMENT OF HON. JOHN D. ROCKEFELLER IV, A U.S. SENATOR FROM THE STATE OF WEST VIRGINIA

I would like to thank the Chairman, Mr. Stark, for calling this important hearing today. I greatly appreciate the opportunity to testify in support of legislation of considerable importance to the health and well being of the nation's elderly.

Congressman Coyne is to be commended for the leadership role he has taken in improving mental health care for this country's older citizens.

I believe Medicare coverage of psychologists' services will go a long way towards meeting the elderly's tremendous need for mental health services. The need for mental health care among the nation's elderly is at least as great as the generalpopulation, and some studies suggest that the need for certain services may be even be greater.

While nearly 7 million elderly need some type of mental health assistance, only a few are receiving that help—as many as 80 percent are not receiving the care they need.

Without appropriate care, many seniors are forced to live unnecessarily unhappy, confused, or institutionalized lives. A large number of elderly, labeled "senile," actually have reversible, treatable conditions and, if appropriately recognized and treated, could continue living independently in the community.

Unfortunately, the elderly receive less mental health care than any other age group.

There are many reasons why this is so. Many older Americans are reluctant to admit mental health problems and attempt to deal with problems on their own. Frail and homebound seniors, elderly nursing home residents, and older persons with transportation problems have a hard time getting mental health services.

Medicare contributes to the access problem by failing to reimburse mental health care provided by a psychologist.

In my own state of West Virginia, there is not one psychiatrist practicing in 60 percent of our counties; and 73 percent of our psychiatrists are in only 3 of our 55 counties. Almost 40 percent of the rural elderly in West Virginia live in areas without a psychiatrist.

In my state, when a steel plant or a coal mine closes, throwing hundreds of men and women out of work, when floods ravage entire communities and tear down schools and homes, when a tragic accident strikes a family, I know psychologists have been there to reach out and to help out.

That's why I feel it is so important for the Medicare program to catch up with other health insurance programs and state laws, and give senior citizens both the choice and the ability to be treated by professionally trained psychologists.

Expanding coverage for psychologists' services would undoubtedly improve access to mental health care in a state like West Virginia, and many other states that have regions typically underserved.

This is a beneficiary issue. I feel strongly that Congress has the obligation and the responsibility to make sure that Medicare beneficiaries are able to obtain the vital mental health services to which they are entitled and not be shut out because of where they live.

Senior citizens want to choose their own health care provider. Expanding Medicare coverage would give seniors the opportunity to choose the mental health provider that is right for them—it gives them freedom of choice.

S. 100 and H.R. 774 would also help seniors with out-of-pockets costs by requiring psychologists to accept "assignment." What this means is that a beneficiary would not have to pay for any additional charges above what Medicare determines is a reasonable charge—a safeguard that is extremely important to beneficiaries.

Only highly-trained and experienced professionals—mental health professionals that are licensed by their state to diagnose and treat mental disorders—would be able to receive reimbursement by Medicare.

I was glad that two years ago, Congress (in OBRA 1987) authorized coverage of mental health services provided by psychologists practicing at rural health clinics and community mental health centers. I hope this year, we can agree to completely remove an artificial barrier to mental health care for this nation's older Americans by authorizing Medicare reimbursement for psychologists' services.

Chairman STARK. I want to thank you for your most interesting testimony.

I have a question that has concerned me, which I also think will be of concern in this hearing. You perhaps could at least add your opinion.

There seems to be a bit of jurisdictional debate that we will hear, whether it is as I alluded to: Can the masters of social work get in at the less extensively trained end of the scale or should only the psychiatrists at the more expensive end of the scale be allowed into the game, or must they work for the more extensively trained professional as a gate-keeper?

If you are not much more informed than I am in this area, you probably have trouble spelling the various diagnoses and treatment than understanding what they do. I am not sure that should be our

issue, but in your testimony you underlined that mental health professionals are licensed by their State.

My question is—and I suppose this could only hold to the State of West Virginia—but going through whatever kind of licensing boards your State went through, there must have been input from M.D.'s, social workers, psychologists and anyone else who wanted to toss their 2 cents' worth in, to come up with a set of rules to determine when it is safe or desirable for a patient to be treated by a psychologist and not an M.D., or a social worker and not a psychologist.

We will hear testimony to the effect today that a psychologist cannot prescribe some kinds of drugs and therefore the patient may not get the appropriate treatment. I have no way of judging that, not being a professional. I am content with the State of California's laws covering that. I wonder, however, if I am being too parochial.

Do you have any feeling about allowing the States to make these decisions?

Senator ROCKEFELLER. I have no discomfort. I do have problems with claims that psychologists unwilling would not know when to refer patients elsewhere for medical treatment. There have been all kinds of studies done on this which show this is not the case. The psychologists understand what it is that 7 years of training tell them to do, and when referral is necessary they are entirely prepared to do that. I think that is not so much a question of the licensure of the State as it is the integrity of the psychologist. I have no doubt on that question.

I keep coming back to my own State, which is peculiarly rural. Psychologists are more likely to practice in rural settings, psychiatrists do not.

Chairman STARK. So the psychologist, in any event, is 10 times better than the guy who runs the general store, and some care is better than none?

Senator ROCKEFELLER. The "some care" factor is extremely substantial when it comes to what a psychologist offers—not just to seniors, I might say. I really have to say I have been at many mine disaster sites and I have seen how psychologists help the families of those who are lost inside. They wait for 2, 3, or 4 days always hoping but you know they are not coming out. It is the psychologists who have been there.

I watched towns wiped out by floods in 1977. The psychologists were there.

Both psychologists and psychiatrists, incidentally, in my judgment, are totally prepared—both of them are prepared to make referrals toward specialties when that is necessary. I don't say the psychologists are better than the psychiatrists; the psychologists understand when they cannot do something, they make the referral. Studies have pointed this out.

Chairman STARK. Thank you.

Mr. Gradison.

Mr. GRADISON. I have no questions.

Chairman STARK. Mr. Levin.

Mr. LEVIN. I have no questions.

It is most helpful testimony. I think you have given here, as well as on the other side, a boost to this issue. I hope it will happen this session.

Chairman STARK. Mrs. Johnson.

Mrs. JOHNSON. I have no questions, Mr. Chairman.

Chairman STARK. Thank you, Senator. It is a pleasure to have you with us today.

Our next witness, new in his role as a Member of Congress, is the Honorable James McDermott from the State of Washington, a psychiatrist and a person who has had a great deal of experience in legislation in the health care field in the State of Washington as a member of the State legislature. I am sure he is a person we will see a lot of in this committee, because he has agreed to help us in the thorny deliberations we will have ahead of us.

It is a pleasure to welcome you as a witness today, Jim. Your prepared testimony will appear in the record in its entirety. Why don't you proceed to expand on it or enlighten us in any way you are comfortable.

Mr. MCDERMOTT. Mr. Chairman, I would like to read my testimony. It is very short and it will serve as a basis for people to ask questions.

STATEMENT OF HON. JAMES A. McDERMOTT, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WASHINGTON

Mr. MCDERMOTT. I am honored to appear before you during my freshman days as a Congressman from Washington State. During the 15 years that I served in the Washington State House of Representatives and State Senate, I served as chairman of both the Budget Committee and the Ways and Means Committee, so I have a profound respect for the issues with which you struggle: how to provide public services and also how to pay for them.

Being a physician, I also have a deep and long-standing interest in providing access to quality health care. In 1980 I wrote and passed nursing home reform legislation, which included both financing reform and quality of care standards. I also sponsored legislation to create the Medex program, which was designed to use the talents of returning Vietnam medics to extend the available health care to underserved areas of the State.

I sponsored legislation to expand the scope of practice for nurses so that their skills could be used to the maximum. And, finally, I wrote and passed the Washington Basic Health Care Act in 1987, an act designed to provide a model for health care delivery to the working poor of this country. In short, my legislative goal has consistently been to broaden access to quality health care for the people.

I offer this history simply because I think it is important to know the perspective which each witness brings to their testimony.

It is, I suppose, important at this point to add that I sponsored the licensure law for psychologists in 1971. When I went before the committee there, the chairman was a chiropractor and he said it was the first time he had ever seen a psychiatrist do something for somebody else. I did that because, from both a professional and legislative point of view, the addition of psychologists to the health

care delivery family is a very positive addition to good health care. My distinguished colleague from Pennsylvania is to be commended for his proposal, H.R. 774, which would allow payment for psychologists' services through the Medicare program.

The Medicare population is made up of individuals who are either disabled or elderly. By definition, they are people who often have more than one problem. They may have two medical difficulties requiring medications which are opposite in action, or they may have emotional or mental symptoms caused by medical illnesses alone or in combination with the stresses of life events.

For example, a patient may have thyroid disease or other endocrine disorder, or a problem with medication for treatment of high blood pressure, and at the same time be experiencing the symptoms of depression.

Let me define that. That is just doctor talk for looking at a patient who has symptoms and listing all the things that could cause those symptoms.

Chairman STARK. That can be done by a family practitioner or internist?

Mr. MCDERMOTT. Yes.

Every physician is expected to do a differential diagnosis. If he has a pain in his arm, it could be anything from tennis elbow to cancer, so you have to look at all the possibilities.

In order to give quality care for the symptoms of depression, a differential diagnosis and treatment plan must be developed. Medical training is required to make such a diagnosis, and for that reason there should be a required medical differential diagnosis before treatment is begun.

When I graduated from medical school in 1963, there was no special training in geriatric diagnosis at the University of Illinois. In fact, there were very few physicians who specialized in the field of aging. Over the 25 years that I have been practicing psychiatry, we have learned infinitely more about the problems of the elderly and we have made many advances in the treatment of the general medical problems of our senior citizens.

The use of an increasing number of prescription medications to treat the various conditions of increasing age has made the problems of differential diagnosis ever more complex. For this reason alone, a careful diagnostic process should be a part of the treatment of any elderly person. I know that my colleagues in psychology would not disagree with this formulation.

With an amendment requiring a medical differential diagnosis, I think H.R. 774 deserves your positive action. It offers the chance to add another skilled group of practitioners to help in the care of our parents and grandparents.

Chairman STARK. I guess my question centers around that differential diagnosis. Sometimes when I go to have my annual physical, I am sent over a questionnaire? Do I live alone? Am I happy? Am I short of breath? Do I get up in the middle of the night. I send it back and I never see it again. I assume it is probably reviewed by a medical doctor. It is probably by exception, so if you learn to pick the right answers you won't have to go anyway.

Is that a differential diagnosis or could one be handled by a nurse practitioner under the supervision of a doctor? Or does it mean that it has to be a hands-on, face-to-face interview?

I can't quite get the level of intensity there.

Mr. McDERMOTT. There are several things that go into a good differential diagnosis. There is one called SAAP--symptoms, analysis, assessment and plan. You must take a history. Certainly it shortens the time if you have filled out a comprehensive piece of paper and the doctor can go through and see, well, I notice you say you have shortness of breath. You need to talk to the patient.

The aphorism of William Messler, the father of American medicine, is: Listen to the patient. Second, you have to do an examination, you have to look, listen and feel whatever the problem is. That is the second part, and sometimes it is required that you want to do some kind of laboratory tests. So that is all part of the careful differential diagnosis.

Medical care today is not all done by physicians. Many times there will be a screening nurse who will do some of this, somebody who has had expanded practice training, but in many instances it is coordinated by one person.

Chairman STARK. Senator Rockefeller's problem is compounded because he probably has as big a shortage of professionals, primary care professionals, in this area where he also has a shortage of psychiatrists. I have the same problem.

We were in Stockton recently where we had a lunatic with assault rifles shoot up a bunch of kids in a playground. As I understand it, a group of counselors came in for the kids who were upset, and for their families. In a situation like that, isn't it arguably better to move these counselors in and let them counsel and take the risk that someone needs a tranquilizer or an injection?

I am trying to get at the practicality of saying that every time someone needs psychological counseling, do they also need a full-fledged physical? Do we want to have Medicare pay for this? In this situation all we have been able to do is mammography.

I wonder if there is a happy medium? It sounds like your amendments were drawn tightly enough so that we would not do significant—I mean I think it could be drawn like that, where you would have to have a referral.

Is there a middle ground?

Mr. McDERMOTT. There certainly is. I also come from a rural State that has large numbers of people who live in rural areas. We are talking about Medicare population. You were talking about a little bit different population in that you are dealing with people who you assume have no medical problems or they would be under continuous care—younger people.

But when you are dealing with elderly persons, you will hardly ever see anybody in a nursing home who doesn't have a medical problem that needs to be assessed before one decides that they are depressed because they are old or whatever. They need to find out if the medications they are taking are too much or too little or whatever.

I think an assessment in this instance is very important. You may be treating somebody with beginning Alzheimer's disease or possibly carcinoma that has spread to the brain. Psychologists are

not going to fix something like that. The psychologists would want to know that, too. You would not want to draw the amendment so tightly that there is no possibility of anybody ever being seen.

I think Mr. Levin made the key point, that is, to be sure people have access to quality care. That is certainly my goal.

Chairman STARK. She will hate me for this, but Mom, if I call late in the afternoon, is apt to have slurred speech on occasion. We say, "Mom, one martini." That is my diagnosis.

It is conceivable that someone with more training might spot something. A psychologist might see that she has not had three martinis but rather has something else wrong.

Isn't half a loaf better than none? Aren't psychologists better attuned to be alert to the ancillary or indeed primary problems that can cause it?

Mr. MCDERMOTT. I may misunderstand your question, but it sounds as though it is an either/or here. I see it as a collaborative thing.

A psychologist who in the course of going through a nursing home saw a patient who had a question would not consider treating such a patient without first having them seen by a physician. They would think to themselves, this could be a stroke or a lot of things, so I want to be sure I know what is medically going on.

I understand turf warfare. With 15 years in the State legislature I have seen that. If we get into that sort of thing, we will lose what is best for the senior citizen.

In answer to your question as to wouldn't it be better to have half a loaf than no loaf, I think we can say we will pay for psychological treatment but we want to get the medical diagnosis done at the same time.

Mr. LEVIN. You are such a valuable resource, we might take a few more minutes and throw you even further into the south on this.

I think the chairman's question really gets at the nub here. Reading the testimony, it was pretty clear, at least to me, that that is what it is, the testimony that we will hear later from the distinguished representative from the American Psychiatric Association. He zeros in on the point you have discussed.

It says the medical differential diagnosis is a complex one requiring the expertise of physicians. Psychologists are not capable of making this differential medical diagnosis.

Let me enter further into the fray. Your reputation is such that you don't hesitate.

My first question is this: Isn't it likely in many cases that there will be a contemporaneous diagnosis of a patient? Elderly people under Medicare see physicians rather regularly. Isn't it possible to devise a system so that this would be required for reimbursement where there are physicians available—there might have to be some exclusions—some kind of a current, if not concurrent, medical evaluation of the patient available to the psychologist?

Mr. MCDERMOTT. It seems to me, if I understand that question, that that is what you would want, that a psychologist before they began treating would say to the patient—and you have to see where does the physician come in; does the physician say to the pa-

tient I think you have some emotional problems that could be best treated by a psychologist? That would have already been done.

The other way it might happen is someone comes to a psychologist because they are feeling depressed or they are sent by their spouse because they don't seem to be acting right. The psychologist would then say tell me who your doctor is, and then would be sure they had from the physician a medical differential diagnosis.

I think that would fulfill what you need here, to be sure the psychologist has the results of this before they treat somebody for 6 months or a year.

Mr. LEVIN. So you don't need to conjure up a system where, when somebody comes in to see a psychologist, there would be a new referral back to a physician which would not be covered. But the psychologist would be required to talk to the physician, and in most cases the Medicare patients would have a physician.

We could contemplate an amendment which would say to psychologists that there must be referral to you by a physician who has examined the patient and can give the psychologist a written document to be sure that the problem is not a medical one; in lay terms, it is not medical but psychological. Right?

Mr. MCDERMOTT. Yes.

My sister is a Ph.D. psychologist. I have collaborated with psychologists for 25 years. I cannot imagine a competent psychologist who would not want that kind of assurance before treating an elderly person.

Mr. LEVIN. If we built into this legislation that kind of a caveat—and there would have to be some exceptions probably where physician's services were not available—can you think of any compelling reason, with that kind of amendment built in, anywhere to refuse to reimburse psychologists?

Mr. MCDERMOTT. No. I am basically in support of the bill.

Mr. LEVIN. If we get at that issue of the differential diagnosis, you don't think there is a valid reason, within your experience, for refusing any longer to reimburse the psychologist?

Mr. MCDERMOTT. No.

Chairman STARK. Mrs. Johnson.

Mrs. JOHNSON. Welcome, Congressman McDermott. There are not many of your sort in our body. To have the experience of somebody with your medical training and experience is a tremendous asset to us in the Congress. It is a pleasure to welcome you.

Perhaps you would discuss in somewhat greater detail the rights of psychologists to prescribe versus the rights of psychiatrists to prescribe, if you know how many States allow psychiatrists to prescribe medications without having that aspect of their work under the direction of a physician.

Mr. MCDERMOTT. I think maybe, if I understand your question, you referred to psychiatrists "prescribing." A psychiatrist has been in medical school and has 2 years' medical internship and further training. I am not aware of any specific instances where psychologists are allowed to prescribe medication.

There may be some States that have that in some specific situations, but certainly not in a general practice in a private office. There is no place in the United States where that is possible.

Mrs. JOHNSON. So you are not concerned with the medication mix, when you talk about differential diagnosis and treatment plans, that a psychologist would prescribe something that might not be suitable in light of other medications because psychologists don't prescribe drugs?

Mr. MCDERMOTT. Right.

Mrs. JOHNSON. So you are really concerned about the possibility that a psychologist in counseling with an elderly person could overlook a treatment, treat it like a psychological symptom when it was a physical symptom?

Mr. MCDERMOTT. That is correct.

I think you are looking at a situation where a psychologist would treat a person who comes in saying I have a symptom; it could be pain, an emotional feeling or a limitation. The diagnosis of that symptom is here. The physician says maybe we could put them on some anti-depressant drugs, but I also think it would be good for you to talk to doctor so-and-so who I know in your local town.

That is the treatment plan, the doctor giving medication and the psychologist giving the psychotherapy.

Mrs. JOHNSON. I see your amendment as representing a real barrier to this legislation having an impact. If we are going to limit the legislation, I think perhaps limiting it from the other direction, requiring psychologists to notify the person's physician that they are seeing them to report to the many symptoms that might have dual indications.

One of the barriers to access right now is saying that "my parents see a psychiatrist". In their day and age, psychiatry was a dirty word, and if you think they are going to see a psychiatrist—I think there is a problem with the current generation in terms of their view of psychiatry that inhibits them from reaching out to sources of care from which they could truly benefit.

I am reluctant to have a clear prescription for seeing psychologists through medical referrals. I am open to compromising it from the other direction.

Chairman STARK. Mr. Moody.

Mr. MOODY. I understand from your answer to Congressman Levin that you would be amenable if the caveat was put on the amendment so that it did not apply where there were access problems, where the people would have difficulty in getting to the doctor.

Do you think that is not an issue because we are not talking about getting to a psychiatrist? We are only talking about a GP, correct?

Mr. MCDERMOTT. You are talking about a medical diagnosis that could be made by more than one type of specialist.

The real issue is having someone looked at. There are very few cases—I mean, I have rural areas in my State where it is a long way to a physician. If you have a senior citizen who is confused or not doing well, to simply treat them as though they are having emotional difficulty where there is a potential of treating it physically, I think it is worth the time to make the referral.

I know in the State of Wisconsin you probably have distances similar to my own, maybe a couple of hundred miles, but in the

end you would do the patient a better service than saying the doctors are too far away.

Mrs. JOHNSON. Clearly where someone is going to prescribe drugs or any kind of medication, you would not want to proceed without something like this. I clearly understand.

Where someone is providing simply psychological services, do you think the differential diagnosis should proceed, or should we let the treatment commence on the understanding that it be administered at some point?

What downside could there possibly be in the early phase to get started if a differential diagnosis did not occur until after a while, since we are not giving them any medication?

Mr. MCDERMOTT. I suppose it is really the question of what the patient loses. Let me see if I can give you an example of something that might make sense.

If you have ever been sick for a long time, in bed, you might feel depressed. We could say we will bring in the psychologist to come in and talk to you. You would not want that to proceed very long without getting the diagnosis of why you are sick and in bed.

This is the issue. You want that to happen at the beginning of the treatment. It is not that one could not go to a psychologist and get paid. If I were a psychologist and saw somebody for the first time, I would say you ought to go and see your doctor or let me call your doctor and find out if there are any physical problems that are creating your problems.

You would not want to go 6 months before you got that evaluation done. That is what I am driving at.

Mrs. JOHNSON. Presumably most people in that status would want to see a doctor anyway if they could not get out of bed.

I am wondering what the moment is of your point. I do not disagree with what you say. The medical regime would be seriously compro. ed if this did not happen as a precondition. You would like to make it a precondition, wouldn't you?

Mr. MCDERMOTT. I think it should be part of the beginning of the treatment.

Mrs. JOHNSON. But not necessarily the first thing?

Mr. MCDERMOTT. It ought to happen at the very beginning.

Mrs. JOHNSON. What if it doesn't happen right away?

Mr. MCDERMOTT. If there is one visit with a psychologist and they say to the patient it looks like we can do something with psychotherapy but you need to see your doctor.

Mrs. JOHNSON. So it is not an absolute position on the initial visit?

Mr. MCDERMOTT. Early on.

Mrs. JOHNSON. But the initial visit would still be covered under Medicare.

Mr. MCDERMOTT. Sure.

Mrs. JOHNSON. So the psychiatrist would not have a gate-keeper role under your amendment.

Mr. MCDERMOTT. I think you are leading the witness here.

Mrs. JOHNSON. Would there be a gate-keeper role?

Mr. MCDERMOTT. I have been collaborating with psychologists for 25 years. I look at that, not as a turf battle. I don't think the committee should see it as that.

Mrs. JOHNSON. I know you are not looking at it as a turf issue, but turf questions spring from this amendment, or the way it is applied could raise turf implications.

Without leading the witness, is it your intention that the doctor certify or in some sense be a gate-keeper for subsequent psychological services?

Mr. MCDERMOTT. I don't think that is as important as long as the medical part has been taken care of and the decision has been made about what is appropriate treatment on a medical basis. If there is psychological treatment, that is, then that should be done on the basis of that. But you ought to have the differential diagnosis done so that you have eliminated the possibility of a physical thing which exists and is not treated.

Mr. MOODY. What if the doctor says, "There is no medical, no physical ailment that I can see that you should be treated for; as to your need for psychological care, I have no opinion one way or the other." Would that pass muster, then, for Medicare reimbursement?

Mr. MCDERMOTT. My feeling at that point, if the patient has come in and said, Doctor, I am depressed, and/or I can't think or I can't—I am not interested in the activities I used to be interested in. If they come in with some kind of symptom like that, I can't imagine a physician saying you were seen by Doctor so and so and sent to me and I think you probably ought to go and talk to him about some of the things. I find physically there is no reason why you should be feeling this way. Your heart is OK. Your lungs and kidneys are all right and you are obviously upset about something and I think it would be good for you to talk to a psychologist.

Mr. MOODY. But what if the doctor didn't say that? There are doctors who don't think psychologists have much to offer, just as there are those who think they have a lot to offer. I am looking at the case of the former. Would we not want that psychologist covered under Medicare?

Mr. MCDERMOTT. I think they should be and the patient should make a choice.

Mr. CHANDLER. I might point out that from the historical perspective that the witness provided, I was alongside him in the House of Representatives, and we often sat across tables from one another trying to hammer out budgets. It is good to see him here in the Congress.

He is a good colleague and, I think, as you said, Congressmen Levin, that we ought to take advantage of our resources here. The thought occurs to me that if you adopted the amendment that you are suggesting for the medical differential diagnosis that, notwithstanding the responses to the questions by the previous questioner, there would not be much difference between the new law and the current law in that today a physician can refer an elderly patient to a psychologist, and the psychologist can seek reimbursement, albeit through the physician. A psychologist can also receive reimbursement by referring the patient to a physician.

So other than to achieve direct reimbursement, I am not sure that with your amendment, the way I understand it, there would be much difference between the new law and current law. I don't

know if you want to respond to that or if that makes any difference to you. It is just my observation.

Mr. McDERMOTT. The provisions of present law to my understanding is that psychologists are not reimbursed unless they are working in a clinic. Under Medicaid, there are some instances where psychologists are reimbursed at the discretion of the States.

The States have the ability to do that, but under Medicare I am unaware that the psychologist can receive direct reimbursement now except in a clinic situation.

Mr. CHANDLER. My understanding is that psychologists must work under the direct supervision of a physician. I don't know if it has to be in a clinic.

Chairman STARK. It is my understanding----

Mr. McDERMOTT. Under the supervision of a physician that is another situation.

Chairman STARK. I believe that the law we passed a year or 2 ago said that in a community mental health center, a beneficiary can have direct access to a psychologist as well as to rural clinics. Now, one would presume with rural clinics, that there is a physician on the staff. I don't know what the rules are in dealing with community mental health centers, however, I believe if there is not a physician on the staff, there is certainly one in consultation. I would be interested later on in finding out if States treat this differently. But we are providing it and I am not sure that in the community mental health center rules and regulations there is anything that says you must have a physical or a differential diagnosis.

One might presume that, but I don't know and I think we can find that out in the course of our deliberations. I just don't know the answer to that.

Mr. McDERMOTT. You would be medically liable, I think, if you hadn't done it, both the psychiatrist or the psychologist. You are really looking, if you get into the legal end of it and you go to court and you are asked, did you do a physical? No, I am not qualified because I am a psychologist. Did you refer them? No. Why not? Then you get into the whole question of why was something not ruled out.

Any physician would be—a psychiatrist is vulnerable to that same thing as a psychiatrist. If you see a patient and you treat them as now they are physically healthy, but you have not, for your own professional self, satisfied yourself that they are physically OK, you are liable for malpractice for not treating well. So it is not something that the psychiatrist is free from simply because he has been to medical school.

He has to be satisfied that that is true.

Mr. CHANDLER. Another line of questioning has to do with the prioritization of spending, which I think we will do a lot of in this Congress. As a psychiatrist, what is your professional opinion on the kinds of illnesses, or range of illnesses, that you would be likely to see in elderly patients who come to you now, for treatment of mental disorders?

Mr. McDERMOTT. I worked for several years on the staff of the Pacific Medical Center in Seattle, which is a hospital that deals with a large number of retired military people. So I saw a lot of

people who were elderly in that situation and the most common thing I saw were people who were depressed and who were either at the same time coping with some kind of chronic illness or had some acute illness, had cancer, or something had been diagnosed. That is the most common thing.

Another thing I saw very frequently were spouses who brought their wife or husband in and said, "George isn't acting right." Or, "George doesn't think as clearly or he lays around all the time and he doesn't—and I think he is—something is wrong with him." And I would see people in that situation and I would immediately want the hospital chart and want to know what was going on with him physically before I started talking with them about how they felt about getting old and not having a job and things that trouble older people.

So I would see people when they lost their driver's license, you would be surprised how much a driver's license means to people in terms of competence in society and when they can no longer get their driver's license, it would be those kinds of things that would bring people in. And I would also make sure that they were seen or they had been seen by a physician.

So it was generally either a lack of energy or a lack of performance or depression were the most common things that I saw.

Mr. CHANDLER. Of those cases, just estimate how many of them do you think would require the kinds of services that only a physician could provide? It sounds like depression was the most common illness that you ever saw.

How many patients would you treat with anti-depressing medications?

Mr. MCDERMOTT. Probably a quarter to a half. Our clinic was two psychiatrists and two psychologists and we traded patients back and forth all the time. Sometimes I would see the patient once and make a diagnosis and put the patient on medication. They would continue to be seen by a psychologist or sometimes I would see them by myself. So I would say somewhere between a quarter and a half of the patients in that clinic were taking some kind of anti-depressant or some psychological medication.

Mr. CHANDLER. Would a general practitioner likely be able to accurately determine the need for that medication and prescribe it, without the assistance of a psychiatrist or a psychologist?

Mr. MCDERMOTT. I don't know today what the figures are about how much of psychological or psychiatric medication is prescribed by general practitioners. I know that it is a considerable number of prescriptions by nonpsychiatrists. It really depends on their own attitudes. Some are willing to do that; some are not. But the basic thing they are doing is ruling out a physical illness.

If they decide there is not a physical illness, then they maybe willing to do the next step and prescribe medication or refer someone, depending on the location. If you are in a rural area you may do more than if you are in the middle of Seattle where you can refer somebody across the street. And I think that is a determination of local availability as much as anything.

Mr. CHANDLER. OK. That is helpful. I don't want to abuse my allowance of time here. Let's get on to the question about priority. I note that when a parent dies or a spouse dies or when a person

retires, any of those major life-changes, cognitively cause depression. It is very likely to be a result. So aging carries with it a number of occasions, and probably cumulative in their effect, that result in some depression.

But it seems to me that it is pretty clear that the loss of a driver's license is going to be, regardless of its effect on a person's mental attitude, nothing even close to life-threatening like some of the other medical illnesses. And that being the case, we know that this year this committee will very likely extend the provision which requires senior citizens and elderly participants in Medicaid to pay 25 percent of its cost while 75 percent is borne by other taxpayers. At the same time, we know that there are other important health concerns, such as children's health, prenatal care for mothers as well as other issues.

Are we dealing here with a priority that stacks up against those other areas that are crying out for expenditures to respond to unmet needs. It would be awfully nice to have someone to talk to and to assist with those periods of time in our lives that we know are coming. As a professional and a Member of Congress, is this, in your opinion the highest priority that we are going to have for expenditure, not just Medicare funds, but taxpayers funds that have crying needs elsewhere?

Mr. McDERMOTT. I guess you give me the opening, I will talk about national health insurance. Obviously, I think that there are lots of areas that need it. This is not the only one. It is the one that happens to be before you and that is why I am here. But I really think that there needs to be a national health care system. And I personally am willing to do things to make it possible to have a more comprehensive system.

I think I started my testimony saying I know what the Ways and Means Committee is all about. You have to make choices between things that we would all like to do. And I think this is certainly something that should be considered, but if you are going to do it, I think you ought to do it in a way that you get the best treatment for the senior citizen.

That is my only point. Making the other judgment, I guess I would lean toward raising taxes, so you could provide national health insurance where you might not otherwise. So I think there is probably some, you know, when you get to that bigger decision, that is a much tougher decision.

Mr. LEVIN. Would the gentleman yield?

I think the question is, and your experience is unique, how important is mental health care for the elderly? I think that is what the question is.

Mr. McDERMOTT. I think it is much more important than we have allowed ourselves as a nation to observe. I think a big part of our senior citizens' lives—when I did the study and brought about the nursing home reform, we spent a lot of time working on the issue, quality of care standards and how do you raise the level of psychological care in nursing homes.

It is probably one of the most neglected areas in our whole health care system and we, I agree with the opening statements that said that if we were to treat people psychologically, we would save a lot of people from going into nursing homes.

I think if we were able to give them the kind of support in their own homes—so you really need a long-term care policy. There is a whole range of things that are missing. I think it is money well-spent in terms of not only humaneness, but just in terms of keeping people out of nursing homes.

For that reason, I think it is a good expenditure of money to treat people on an outpatient basis with psychologists or psychiatrists or anyone else that is qualified to do that.

Mr. LEVIN. Thank you, Mr. Chairman.

Mr. MOODY. Mr. Chairman, Mr. McDermott, since psychiatrists may not provide the kind of markup or differential diagnosis that you remember, would you say that a psychiatrist should also refer a patient to a GP or to someone to do that sort of thing if he or she does not do it before they go on to psychiatric treatment?

Mr. MCDERMOTT. I think a psychiatrist should be responsible for it, either do it himself or have someone else do it. And under the law, he is presently.

Mr. MOODY. Thank you.

Chairman STARK. Jim, thank you very much. I can tell by the concern and interest of our committee that your testimony was enlightening for us this morning.

Our next witness is Dr. Melvin Sabshin, the medical director of the American Psychiatric Association. I am sorry. It will be Dr. Bryant Welch, who is director of the American Psychological Association, joined by Dr. Nicholas Cummings, who is a member of the California State Psychological Association.

Following that, we will hear from Dr. Sabshin.

As is the custom, we will be running timing lights as an indication of time expired for the witnesses and members of the committee that are questioning and our review of prepared testimony which without objection will appear in the record in its entirety primarily as a courtesy to those witnesses who drew shorter straws and are further down on the agenda.

With that I would welcome you to elaborate, expand on, summarize your testimony in any manner you are comfortable, understanding that members will probably inquire about your testimony and give you a chance to expand on areas of which they have particular concern.

Dr. Welch, would you like to begin?

STATEMENT OF BRYANT L. WELCH, J.D., PH.D., EXECUTIVE DIRECTOR FOR PROFESSIONAL PRACTICE, AMERICAN PSYCHOLOGICAL ASSOCIATION

Mr. WELCH. Thank you.

Chairman Stark, members of the committee, good afternoon. I am Dr. Bryant Welch, executive director of the American Psychological Association for professional practice. I am a board certified clinical psychologist and a licensed attorney. The American Psychological Association is the membership organization for the 90,000 psychologists who are engaged in the practice, research, and teaching of psychology in this country.

Medicare is unique among virtually all existing health care plans in that it does not provide beneficiaries with direct access to psy-

chological care except in community mental health centers and rural health clinics. As a result, our Nation's elderly are suffering and of the 23 million elderly in this country, about one-fourth have a disorder that requires mental health care. Depression, suicide, cognitive impairment, disorientation, anxiety disorders, and a variety of other behavioral disorders are commonplace with our nation's elderly.

But the National Institute of Mental Health estimates that 50 to 70 percent of the mental health needs of the elderly go unmet. And of those who do get care 75 and 85 percent of all mental health services received do not come from a mental health professional but, instead, are rendered by general physicians who typically have less than three months of mental health training.

Studies have shown that general physicians completely overlook mental health needs in about 50 percent of their elderly patients and even worse, when they do consider them, 40 to 70 percent of the time they misdiagnose the mental health problem. It is important to keep this fact in mind in terms of the "differential diagnosis argument." When it comes to actual treatment, instead of using appropriate psychological techniques, the medical community is currently overutilizing psychiatric drugs to such an extent the Inspector General of DHHS recently referred to the problem as "our country's other drug problem."

Again, think of the differential diagnosis arguments. For those of you concerned with Medicare expenditures, consider that every year drug overdoses in the elderly cause 32,000 fractured hips from falls, 60,000 cases of Parkinson symptoms and 150,000 cases of memory loss and dementia. The elderly also have a quarter of a million hospital administrations a year for adverse drug reactions.

This is what we do to these poor people when we do provide care for them. While Medicare does reimburse psychiatrists, the statistics make clear the elderly are not receiving significant portions of their mental health care from them. There are several factors which contribute to this problem. First, many of the elderly do not live close enough to a psychiatrist to use them.

Psychiatrists are not located in two-thirds of all U.S. counties. The more equitably distributed psychologists, however, could fill about 40 percent of those countries where there are no psychiatrists. You will hear psychiatry argue that there are counties adjacent to those without them. But if you take the Federal Government's definition of access, which is in about 40 minutes driving time, almost one-fourth of the rural elderly do not even have that access to one psychiatrist.

Second, psychiatric fees are a problem for many of the elderly. Only about one-fourth of psychiatrists have fees of less than $80 per hour, while about one-half of the psychologists do. Psychiatry always tries to deny it, but every valid study shows that overall, psychologists charge 10 to 15 percent less than psychiatrists. It is also well-documented that many psychiatrists don't like working with the elderly and, as such, simply don't.

The American Psychiatric Association trade paper last month said that most psychiatrists have never set foot in a nursing home.

The question you are struggling with from today's discussion is: Are psychologists qualified to treat the elderly? First, psychologists

are licensed to do so independently in every State in the country. But, second, and most importantly, no other mental health profession, including psychiatry, requires as much training in mental health care as psychology, and according to most research data from the national research council, a doctorate in psychology now takes an average of 7.1 years to complete and that is beyond the 4 year undergraduate study.

During graduate training in psychology and this is extremely important—students receive substantial training in the biological aspects of mental disorders, reviewing in detail the possibility organic basis or the possible medical basis for symptomology taking required courses in psychopathology, and are required clinical rotation. Furthermore, students are examined extensively on their knowledge of the somatic basis of mental disorders and drug effects.

So when we hear talk about a differential diagnosis, keep in mind that is exactly what psychologists are trained to be sensitive to in their training programs.

Mr. Chairman, members of the committee, in closing let me say that this generation of elderly Americans is one of the most remarkable generations we have ever produced. Many were born during the First World War and formed their childhood and adolescent years battling the psychological effects of the Great Depression.

In the young adulthood, they awoke to Pearl Harbor and a war on two fronts. Returning from that they built the greatest economic expansion this country has ever seen. They built schools and highways. They built a vast health care complex for all of us who have come after them. And now as they grow old, Medicare confronts them with a Hobson's choice of psychological abandonment or drugs.

H.R. 774 would change that. Thank you.

[The statement of Mr. Welch follows:]

Statement of Bryant L. Welch, American Psychological Association

Chairman Stark, Members of the Committee, Good Afternoon. I am Dr. Bryant Welch, Executive Director of the American Psychological Association for Professional Practice. I am a Board Certified Clinical Psychologists and a licensed attorney. The American Psychological Association is the membership organization for the 90,000 psychologists who are engaged in the practice, research, and teaching of psychology in this country.

Medicare is unique among virtually all existing health care plans in that it does not provide beneficiaries with direct access to psychological care except in community mental health centers and rural clinics. Indeed, beneficiaries of the other federal health care plans, most notably CHAMPUS and the Federal Employees Health Benefit Plan, have enjoyed unrestricted access to psychological care for many years. Similarly, almost all private health care plans provide direct access to psychologists' services. Psychologists are licensed to independently diagnose and treat nervous and mental conditions in all fifty states and the District of Columbia.[1] Furthermore, psychologists now provide the majority of outpatient psychotherapeutic services that are performed by doctorally-trained mental health professionals in this country, including psychiatrists, and have an exemplary record in terms of safety and cost-efficacy. Yet despite the well-documented need for such services, Medicare beneficiaries are limited to physician providers who, for a variety of reasons, are often ill-equipped to meet the substantial mental health needs of the elderly.

Thus, it is not surprising that Medicare, while providing comprehensive physical health care, is not meeting the mental health needs of the elderly. A review of the Medicare service delivery shows that while even relatively healthy Medicare beneficiaries see a physician every seven weeks for their non-mental health care needs (Koch and Havlik, 1987), the Medicare mental health delivery system is an archaic, outmoded, and unduly restrictive system leading to inadequate access to mental health care, frequent misdiagnosis of mental health problems, and oftentimes harmful treatment of those in need of mental health care.

This report is divided into five sections. The first documents the need for mental health services by Medicare beneficiaries. The second examines the failure of the present system to make quality mental health care available to the elderly. The third documents the competency, quality, and value of psychological services to Medicare beneficiaries. The fourth explores the extremely low cost of the proposal, and the fifth considers both the current support and the current opposition to the measure.

I. THE NEED

Of the twenty-three million elderly in this country, about one fourth have a disorder that requires mental health care (Dupree, O'Sullivan and Patterson, 1982). Indeed, to grow old is to suffer loss -- loss of loved ones, loss of bodily functioning, loss of familiar surroundings, and oftentimes loss of hope for the future. The prevalence of depression, suicide, cognitive impairment, disorientation, anxiety disorders, and a variety of other behavioral disorders are commonplace with our nation's elderly. These problems impact not only on the elderly themselves but also on their extended family and other loved ones.

II. THE FAILURE OF THE PRESENT SYSTEM TO PROVIDE QUALITY CARE

The National Institute of Mental Health estimates that 50 to 70 percent of the mental health needs of the elderly go unmet (NIMH, 1985). Compounding the tragedy is the fact that those who do access the health care system often receive inappropriate and poor treatment. Shockingly, between 75 and 85 percent of all mental health services received do not come from a mental health professional but, instead, are rendered by general physicians who typically have less than three months of mental health training and are

[1] A further anachronism of the Medicare system is that psychologists are the only non-physician doctorally-trained health care providers whose services are not reimbursed to the full scope of their licensure under the Medicare law.

poorly equipped to detect, diagnose, or to treat the mental health needs of the elderly (Swan and McCall, 1987). Those aged that do see their general practitioner are likely to have their mental health problem undiagnosed or misdiagnosed (Rovner et. al., 1986). In fact, mental health problems are overlooked by general physicians in about 50 percent of elderly patients (German et. al., 1987). The result is that potentially treatable disorders are left untreated, thereby, exacerbating the mental health problem. For example, approximately 15 percent of potentially reversible dementias go unrecognized (Institute for Health and Aging, 1985). Estimates are that from forty to seventy percent of the time, the elderly patients' mental health needs are misdiagnosed by the general physician (German et. al., 1987).

Greatly compounding this problem of misdiagnosis is the medical community's tendency to over-utilize psychoactive drugs for the psychological needs of the elderly. Elderly Americans comprise approximately 12 percent of the U.S. population but purchase 35-40 percent of the sedative-hypnotic drugs sold in this country (Moran, Thompson and Nies, 1988). The most misprescribed drugs are valium, xanax, dalmane, and restoril, all of which are used primarily for sleep or anxiety disorders which can oftentimes be far more effectively and safely treated by psychological means. Every year drug overdoses in the elderly cause 32,000 fractured hips from falls, 60,000 cases of parkinson symptoms, and 150,000 cases of memory loss and dementia (Office of the Inspector General, 1989). The elderly have 250,000 hospital admissions a year for adverse drug reactions (Office of the Inspector General, 1989). While medications can be helpful in some cases, oftentimes for the elderly they are being used in lieu of psychological treatments which do not require drugs.

The overmedication of the elderly recently caused the Inspector General of the United States to refer to the phenomenon as "our country's other drug problem." Statistics show, for example, that with many behavioral problems which psychologists could often treat with non-pharmacological means, the elderly, instead, are receiving and becoming addicted to harmful medications. In the area of sleep disorders alone, it is estimated that almost 10 percent of the elderly are addicted to sleeping pills prescribed by physicians (Office of the Inspector General, 1989). Tragically, these iatrogenic drug addicts (who are from a generation that never willfully abused drugs) have never been given the opportunity to try non-pharmacological psychological alternatives. Even more ghastly are the studies which indicate concern for the growing misuse of psychoactive drugs as a chemical restraint for the elderly in nursing homes and other institutions. The authors of a report in the Journal of the American Geriatrics Society refer to this practice as a "silent but potent partner in accomplishing the warehousing of human beings" (Covert, Prodrigues and Solomonik, 1977).

While Medicare does reimburse psychiatrists, the statistics make clear the elderly are not receiving significant portions of their mental health care from them. There are several factors which contribute to this problem. First, many of the elderly do not have even geographic proximity to a psychiatrist. Limited access to mental health expertise under the current Medicare system is a major barrier to the elderly in terms of receiving very basic and necessary mental health care. A study conducted by Applied Management Sciences (1988) documented the state/county distribution of psychiatrists -- the only mental health professionals recognized for all outpatient and inpatient mental health care under Medicare -- and licensed clinical psychologists. This study concludes that psychiatrists are not located in 2/3 of all U.S. counties. The more equitably distributed psychologists, however, could fill about 40 percent of that gap in mental health care coverage.

A SysteMetrics McGraw Hill (1989) distribution study corroborated the findings of the earlier survey and concluded that the maldistribution of psychiatrists is a problem which is seriously impeding access to mental health care among the elderly. There are approximately 25 states in which 10 percent or more of the population live in counties that do not have a psychiatrist but do have one or more psychologists. In addition, an analysis of counties defined as urban or rural found that 75 percent of the rural elderly (1,748,916 persons) live in counties that do not have psychiatrists. About 30 percent of the rural elderly live in countries that have psychologists only.

Results of another study on the distribution issue conducted by Lewin and Associates (Cutler 1989) have been interpreted by the American Psychiatric Association[2], to suggest that access to psychiatrists is not a problem since many of the aged who live in counties without psychiatrists have access to those providers in counties adjacent to where they live. However, "access to psychiatric care" is defined by the federal government in regulations establishing health manpower shortage areas (HSMAs) as "travel time of greater than 40 minutes to these (psychiatric) resources. . . or 25 miles on primary roads" (Federal Register, 1980). Using such criteria, 22.4 percent, according to SysteMetrics McGraw Hill, of the population over 65 do not have access to a psychiatrist. These same people do have access to a psychologist. The well-respected researchers conclude that our estimate of the number of elderly who are not within a reasonable distance of a psychiatrist is a "conservative estimate."[3]

In addition to the problem of geographic access, there are a myriad of other barriers to psychiatrists' services, such as the stigma associated with seeing psychiatrists who tend to be viewed as professionals treating only very "sick" patients. Also, psychiatrists, according to their colleagues, are not attracted to elderly patients and spend less time with them in their clinical practice. According to the Psychiatric Times (February, 1989), the psychiatrists' trade paper:

> "Private psychiatrists have shown little interest in treating patients in the nursing home for many reasons: low reimbursement rates; the myth of the untreatability of the older patient; avoidance of medically ill patients by those interested primarily in psychotherapy; lack of training and experience in intervening in the therapeutic environment and in inservice training of staff" (p. 19).

The article continues on to state baldly, "Most psychiatrists have never set foot in a nursing home" (p. 19).

The fees of psychiatrists also can serve as a barrier to access for many of the elderly who live on very low income. The Psychiatric Times (March, 1989), recently reported that only one-fourth of psychiatrists have fees of 80 dollars or under (whereas over half of all psychologists have such lower fees).

In addition, many psychiatrists may be unappealing to the elderly since few are trained in geriatric care. Similarly, with increased emphasis on exclusively "biological psychiatry," many psychiatrists now have limited training even in traditional psychotherapy, not to mention the newer behavioral psychological treatments which could be so helpful to the elderly as a badly needed alternative to inappropriate drug usage. Psychiatry has also been unable to attract as many medical students as it once did. One prominent psychiatrist reports that while in 1970 about 10 percent of medical students (drawn typically from the upper third of medical school classes) applied to psychiatric residencies, by 1980 that figure had diminished to two percent who were predominantly drawn from the bottom third of the class (Gedo, 1984). A reduction in interest in psychiatry by medical students has apparently forced psychiatry to draw more heavily on students who have studied abroad for their medical training and who have not met the more rigorous standards of American medical schools. Many of these psychiatrists do not speak English as a first language, thereby creating a further barrier to care in the mental health field, where many of the treatments require extensive patient-doctor dialogue. In short, while no one of these factors completely explains the problem, together they do make sense of the conclusion and the bottom line statistic that better than three

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[2]Psychiatrists are the major economic competitor of psychologists and have opposed expanded access to psychological services at every juncture over the last twenty-five years.

[3]For example, in places like Hardy County, West Virginia an older patient would have to drive 77 miles over five mountain ridges and pass through three counties -- each of which has at least one clinical psychologist -- to reach a psychiatrist. Similar examples can be found across the country.

out of four of the elderly with mental health needs do not get seen by a qualified mental health care professional.

It is a simple fact that poor access to a very limited pool of Medicare-eligible psychiatrists contributes significantly to the elderly not receiving needed mental health services. It also contributes to the problem of inappropriate treatment or mistreatment by forcing the elderly to bring their mental health complaint to more accessible primary care physicians who generally are not trained in mental health care and either misdiagnose the problem or prescribe harmful and inappropriate treatment. This disservice to our nation's aged can be substantially eliminated by modifying Medicare law, as proposed in H.R. 774, to allow the elderly access to clinical psychologists.

III. THE SOLUTION - ACCESS TO HIGH QUALITY PSYCHOLOGICAL CARE

The problem of access to quality mental health care for our nation's elderly is not surprising when it is recalled that Medicare is the only health care program which does not give beneficiaries direct access to psychological care. Other federal programs do provide access and give statutory recognition to psychologists as health service providers capable of independently assessing, diagnosing, and treating patients with mental disorders of all kinds. Under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), which provides health benefits to almost 10 million military personnel and dependents, psychologists may independently diagnose and treat patients, both in the hospital and on an outpatient basis. 10 U.S.C. Sec. 1079(a)(13)(Supp. 1986).

Psychologists are similarly permitted to evaluate and treat patients independently under the Federal Employees Health Benefits Program, which covers more than 10 million persons. 5 U.S.C. Sec. 8902(k)(Supp. 1986). Psychologists are also recognized providers under the Veterans Health Care Expansion Act, 38 U.S.C. Sec. 612 A (1982), and the Civilian Health and Medical Program of the Veterans Administration. 23 U.S.C. Sec. 601 et.seq. (1982). The Federal Employees Compensation Act, which provides reimbursement for health services officers and employees of the federal government, includes the services of "clinical psychologists" within its definition of "medical, surgical, and hospital services." 5 U.S.C. Sec. 8101(2) (1982).

The Vocational Rehabilitation Act, which requires assessments of persons with handicaps, both physical and mental, permits such assessments to be made by "a licensed psychologist in accordance with state laws and regulations or both." 29 U.S.C. Sec. 723(a)(1) (1982). Under the Health Maintenance Organization Act, governing all federally qualified HMOs, which serve some 20 million persons, HMOs must cover both inpatient and outpatient basic health services. These services may be provided by, among others, a physician or a psychologist consistent with state law. 42 U.S.C. Sec. 300e-1 (1988).

Finally, psychologists are also recognized in both the Federal Rules of Criminal Procedure and the Federal Rules of Civil Procedure. Rule 12.2(c) of the Federal Rules of Criminal Procedure, which deals with mental examination and expert testimony relating to a mental disease or defect or any other mental condition bearing on the issue of competency, permits either a psychologist or psychiatrist to perform this function. Similarly, Rule 35 of the Federal Rules of Civil Procedure now includes psychologists, as well as physicians, as permitted to perform court-ordered mental examinations.

It is easy to understand the public trust which this statutory recognition represents for psychology when one also understands the extraordinarily high training standards to which psychologists adhere and the remarkably demanding training programs which psychologists are required to complete. Indeed, no other mental health profession requires as much training in mental health care as psychologists. It cannot be overemphasized as to the detailed and intensive nature of the supervised clinical work which the psychologists receive and which stands in marked contrast to the medical school educational style reflected in the saying, "Watch one, do one, teach one."

The minimum training required for psychologists contains rigorous academic coursework, relevant research endeavors, and intensive practical experience leading to the doctoral degree. According to the most recent data from the National Research Council (1987), this training takes an average of 7.1 years to complete. (This is in addition to the undergraduate degree which is typically with a psychology major.) Part way through the doctoral program, the student must demonstrate (by successful performance on a comprehensive examination) a thorough understanding of: all theories of normal and abnormal behavior; clinical diagnostic skills; the full range of approaches to treatment; ethics and professional standards; and research design and methodology. Furthermore, the training includes extensive clinical rotations followed by at least one year of a full-time closely supervised internship experience in a hospital, medical center, or clinic.

During graduate training in psychology, students receive considerable training in the biological aspects of mental disorders. In addition to coursework specifically focused on brain structure and central nervous system mechanisms, clinical coursework includes much more applied biological education. Courses on psychopathology review, in detail, possible organic bases for mental disorders and critically examine the literature on the effectiveness of specific drugs for specific mental disorders, including the expected side-effects. Furthermore, students are examined on their knowledge of the somatic bases of mental disorders and drug effects. In many graduate programs, students also receive training in "health" or "medical" psychology where they become familiar with the physiology and symptoms of medical disorders such as hypertension and cardiac infarction, as well as with all psychological factors related to the cause and management of these disorders.

Receipt of the doctorate alone is not sufficient to enable the independent practice of psychology. In addition, all states require at least one full additional year of supervised postdoctoral clinical experience to become eligible for licensure. Over two-thirds of the postdoctoral experiences take place in hospitals. Only when the individual demonstrates sufficient mastery of psychological knowledge on both written and oral examinations is a license granted for the independent practice of psychology.

Once licensed, a psychologist must confine his or her practice within the scope of licensure and competence. The licensing law of every state and the District of Columbia incorporates an ethical code which makes it both unethical and illegal for a psychologist to practice in an area for which he or she has not received training. In this regard, psychologists are legally and ethically bound to refer to or seek consultation from another professional upon encountering an area outside of his or her competence. Relatedly, psychologists are specifically trained to determine when to refer a patient to a physician for the medical aspects of treatment. Failing to refer to or involve a physician when medical conditions are suspected could result in license revocation proceedings for a psychologist, as well as expose the psychologist to malpractice liability.

The services that this high level of training enables psychologists to provide would be particularly helpful to our nation's elderly community. First, psychologists are experts at diagnosing the most common mental health problems of the elderly which are overlooked by general physicians in 50 percent of the elderly patients (German et. al., 1987). Currently, fifteen percent of potentially reversible dementias go unrecognized and the incidence of a premature diagnosis of "senility" or dementia has been well documented (Institute for Health and Aging, 1985). Psychologists' tests for neuropsychological deficits are invaluable in appropriately diagnosing organic impairments. In fact, psychological testing has been acknowledged even in psychiatric literature to be the only definitive way to diagnose Alzheimer's disease at the present time. (While some psychiatrists administer these tests we have been unable to find any psychiatric programs which provide training appropriate for them to do so.) Psychologists are, of course, trained in the clinical psychiatric interview which is the primary diagnostic tool of the psychiatrist.

In addition to the unique range of diagnostic skills, psychologists also provide a variety of treatments which could be very helpful to the elderly. In the area of sleep disturbances, sexual dysfunction, pain management, depression, family therapy, and even in such traditional medical

areas as post-surgical recovery, post-stroke rehabilitation, and drug treatment compliance procedures, psychologists are unsurpassed in developing non-pharmacological treatment interventions. Furthermore, it should be noted that psychologists' exceedingly low malpractice rate ($450 per year in most parts of the country) is testimony to the safe and the efficacious manner in which they provide these services.

IV. COST

The cost associated with the proposal to directly reimburse psychologists under Medicare is extremely modest. Preliminary Congressional Budget Office (CBO) cost estimates show that the proposal would cost the program $10 million in FY 1989. After year four (1993), estimates show that program costs would be only $25 million. These estimated costs which have been corroborated by two independent sources, amount to a very small fraction of one percent of what the elderly are currently now spending on prescription drugs with their attendant medical expenses and a similarly small fraction of one percent of current overall Medicare cost.

The cost-benefits of mental health care are often overlooked when decisions are being made about where limited health care dollars should be invested. Research over the last decade on mental health treatment, especially on treatment modalities pioneered and used by psychologists, consistently points to the efficacy and cost-savings that can be associated with this type of care. In particular, there is substantial evidence that psychological intervention reduces the use of more expensive medical care. Such offsets are not included in the current cost estimate and, thus, it seems reasonable to assume that the actual net cost of the proposal will be even lower than $10 million.

Studies on utilization patterns of mental health services among the elderly show that the elderly often turn to primary care physicians and hospital emergency rooms to treat mental health needs. Stress, depression, uncontrollable anxiety, and sleeplessness are common conditions among the elderly which directly affect physical health. Older patients with these disorders are often run through an exhaustive list of diagnostic medical tests, lab work, or x-rays. Meanwhile, medical bills are increasing and the mental health disorder continues to go undiagnosed and untreated. The inevitable result: mental and physical health continues to deteriorate. Drug therapy is then introduced with the result frequently being the development of a new set of disorders caused by medication side-effects. Additional medical or chemical intervention is then required to manage the new symptoms. This vicious cycle of events occurs at an alarming rate among the elderly.

Research consistently demonstrates that early, brief psychological intervention suited to the medical and social needs of the older patient can prevent unnecessary and inappropriate medical treatment. (Mumford et. al., 1984). Psychological treatment of older individuals, particularly those who have undergone surgical procedures and those with rehabilitation needs, is unquestionably cost-effective and can off-set many medical costs associated with the care of the older patient. For example, research shows reductions of one to two days in post-surgery hospital stays for elderly receiving psychological intervention (Mumford et. al., 1982).

An independent review of the cost estimates associated with H.R. 774 conducted by KPMG Peat Marwick (1989) also included an analysis of cost-offset factors. The researchers concluded that there is a strong likelihood of substantial cost offsets sufficient to help defray the cost of the proposal and reduce costs in other components of the Part B program as a result of improved access to ambulatory psychological care.[4]

[4]The study estimated an annual cost-offset of about $93 per user in FY 1994, a reduction of less than five percent of projected per enrollee Part B expenditures. If approximately 200,000 new users resulted from expanded provider eligibility, this would result in a cost offset of $20 million. These projections are conservative and assume the maximum time frame (1994) for the clinical effect of psychological services in reducing other medical care utilization.

It should also be pointed out that the impact of competition by psychologists on psychiatrists has been demonstrated to reduce the fees of psychiatrists much to the patients advantage (Mitchell, 1984). Thus, the Medicare beneficiary not only has access to lower cost mental health care in the form of psychologists' services but also has greater opportunity to access psychiatric care if they choose to do so.
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Most would agree that Medicare's contribution to the significant mental health needs of our nation's elderly is relatively small compared to the total amount of federal dollars spent through the Medicare program on services such as hospital care, laboratory services, x-rays and other forms of care offered through Part B. Estimated Medicare outlays (net) for 1989 are expected to reach about $86.7 billion, with Part B expenditures estimated at $40 billion. However, outlays for mental health care are expected to constitute only about 3/10 of 1 percent of total Part B expenditures in 1989. Based on CBO estimates, H.R. 774 would only cost .0333 of 1 percent of total Part B expenditures.

Significantly for today's cost conscious Medicare system, this estimate does not allow for well-documented savings that come from psychological care due to reductions in utilization of other medical care resources and reductions in prescription drug related accidents as well.

V. CURRENT SUPPORT AND OPPOSITION TO THE MEASURE

Many mental health care and elderly advocacy groups have enthusiastically supported the proposed legislation including the National Council of Senior Citizens, the National Association of Area Agencies on Aging, the National Hispanic Council on Aging, and the National Association of State and Mental Health Program Directors.

The only opposition to the measure comes from the medical-psychiatric community. As the lengthy list of statutory recognition for the practice of psychology demonstrates, psychology is now deeply imbedded in our nation's health care system with Medicare being the only major program that does not permit direct access to psychological services. Each and every step in the development of this young profession has been opposed by the psychiatric medical establishment; they always use the same "quality of care" argument and predict dire consequences for granting access to psychological care and for increasing economic competition for psychiatrists. At no juncture has the psychiatric prediction of misdiagnosed physical ailments ever come true, despite the fact that the majority of the non-pharmacological out-patient psychotherapeutic services performed by doctorally-trained mental health providers are ~~now provided by~~ psychologists (Dorken, 1988).

The psychiatrists' argument is always the same and, at first blush, it is somewhat frightening. They raise the spector of "medical" ailments which "psychological" training would not be able to detect.[5] Thus, the argument goes, the "medical" community should have complete control over all patient referrals to protect the patient from the possibility of a missed "medical" diagnosis.

It is, of course, true that psychologists do not attend medical schools. Instead, they attend training programs in clinical psychology leading to doctoral degrees and are very well-trained to provide safe

(Footnote 4 Cont.)
The cost offset projection made by KPMG Peat Marwick is based on a conservative estimate of 5 percent cost savings resulting from less use of medical services as a result of mental health interventions. Research on this usually points to a 15-20 percent cost savings range (Jones and Vischi, 1979). The base from which cost estimates were derived was the projected Part B per enrollee expenditures in FY 1994 for disabled enrollees, provided by the Part B Actuaries office at the Health Care Financing Administration (HCFA). The projected expenditure per enrollee is $1866.00. (Disabled enrollees were used because it is this population which predominantly uses the mental health benefit.)

[5]This attempt to play upon laypersons' fears was made obvious in a recent letter to Capitol Hill offices in which the word "medical" was referred to nine times in one paragraph.

treatment. Given the rigorous seven year training of psychologists previously described, and the very obvious fact that many physical problems are relevant to mental health care, it would be most remarkable if such graduate training did not include thorough training in physical illnesses which masquerade as non-physical illnesses. In fact, psychologists are in the forefront of developing the diagnostic tools to discover the existence and nature of the organic disturbances. And in all cases, psychologists are sensitive to when the presenting complaint suggests the need for a competent evaluation by another specialist, such as an internist or a neurologist. These are the same referral procedures used by psychiatrists and other specialty groups.

It has been remarkable for the psychological community to notice how frequently the allegations made by the medical psychiatric community about psychology are really statements about their own limitations. In the area of misdiagnoses, for example, the problem which has been documented repeatedly is not psychologists' failure to refer for non-psychological medical related problems, but rather is physicians' failure to refer for psychologically-related problems and, instead, to misdiagnose those in need of mental health care. The data also indicates that psychiatrist's misdiagnose 50 percent of the major medical illnesses they see (Koranyi, 1979). In their undaunted fashion, psychiatry has argued that if they, with all of their "medical" training, miss so many diagnoses, than surely psychologists who do not have "medical" training must do even worse. This claim persists despite the fact that there is no evidence to support it, despite the fact that psychologists' malpractice rate as reflected in their malpractice premiums is about $450 per year, and despite the fact that a majority of patients who seek non-pharmacological out-patient psychotherapeutic services choose psychologists. In short, psychologists training and, more importantly, their record indicate that they have learned well the limits of their expertise and when a presenting complaint requires the need of another specialist's consultation.

The same cannot be said for physicians. Psychiatry's insistence on medical referral for psychological care would put the cat among the pigeons. It would also subject the elderly to the horrors of the present system documented above. In short, it would turn a low cost, high quality proposal into a high cost, low quality measure.

In contrast to their lobbyists' assertions, most psychiatrists do not even attempt to provide traditional physical care. Not only are psychiatrists unable to detect major medical illnesses as documented above, but their own research shows that better than 80 percent of psychiatrists do not consider themselves competent to do a physical exam. (Patterson, 1978). This is documented in two separate studies, and in one of them the psychiatrists anecdotally reported their belief that to do so would constitute malpractice (Victoroff et. al., 1979).

Organized psychiatry asserts that the elderly have numerous "medical comorbidities" which a psychologist, because of their lack of medical training, could not detect. The existence of comorbidities is obvious to all and consideration of these issues are well integrated throughout psychological training. If a patient over the age of sixty-five were not in regular consultation with a physician, it would become an immediate focus of inquiry given the prevalence of comorbidities. Again, the documented health hazard in the current delivery system comes from physicians not recognizing the limitations of physician mental health expertise, and not from psychologists' failure to recognize the limits of psychologist expertise.[6]

The opposition from medical-psychiatric groups to patients being given direct access to psychologists can be expected to continue as it has over the last two decades. Rather than leading to better quality care, however, it has led to several lawsuits. Almost a decade ago the Federal Fourth Circuit Court of Appeals rejected, with respect to outpatient care, the very

[6] It should also be noted the average healthy elderly person sees a physician every seven weeks, and for those of poor health the figure is every four weeks (Koch and Havlik, 1987). While this, of course, does not rule out the importance of careful medical referrals by psychologists, it certainly further reduces any risk to which the psychiatrists refer.

same arguments that psychiatrists are making here. The court said, "Forewarned . . . it is not the function of a group of professionals to decide that competition is not beneficial in their line of work. We are not inclined to condone anti-competitive conduct upon an incantation of 'good medical practice.'" Virginia Academy of Clinical Psychologists v. Blue Shield of Virginia, 624 F.2d 476, 485 (1980).

With increasing pressure on the health care dollar, one can expect these turf wars to intensify. However, we believe it is more humane to reduce costs through competition than it is to arbitrarily deny access to those elderly who would like to use a psychologist's services and to force them, instead, to rely on the current antiquated structure. We urge your support for H.R. 774.

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Chairman STARK. Thank you.
Dr. Cummings.

STATEMENT OF NICHOLAS CUMMINGS, PH.D., MEMBER, CALIFORNIA STATE PSYCHOLOGICAL ASSOCIATION, CHIEF EXECUTIVE OFFICER AND COCHAIR, AMERICAN BIODYNE, AND PAST PRESIDENT, AMERICAN PSYCHOLOGICAL ASSOCIATION

Mr. CUMMINGS. Thank you. I am Dr. Nick Cummings, past president of the American Psychological Association and a licensed clinical psychologist practicing in California. I am the chief executive officer and cochairman of the American Biodyne, a large at-risk mental health care system which serves a significant population of elderly in eight States, including Arizona and Florida.

I also administered the first Medicaid HMO capitation contract that was granted to Kaiser Permanente in California after title 18 was enacted. More recently, American Biodyne, with its partner, Blue Cross/Blue Shield of Arizona, was granted one of five experimental delivery grants from the Health Care Financing Administration. And I am proud that I am 65 years old.

Here today, I am representing the 8,000 clinical and licensed psychologists in the State of California who urge your strong support of H.R. 774. Although we do not think of California as a rural State, only 6 percent of the elderly receive care through the State's system of mental health because of serious geographic and physical barriers to care.

State officials report that the elderly are the most underserved of any segment of the population of California. You will hear one argument in opposition to H.R. 774. The medical psychiatric lobby will tell you that it is not safe to let patients see psychologists unless the patient has first been referred by one of them.

We have three responses. First, that suggestion would not only put the cat among the pigeons, it would also perpetuate the current barriers to care. Physicians cannot refer for what they don't detect. Forty to seventy percent of the time general physicians misdiagnose the problem and they have already created a whole new drug problem in and of itself.

Obviously there is very little reason to expect the psychiatrist to refer. Second, the psychiatrists' predictions of misdiagnosis by psychologists have been shown repeatedly to not be true. The data that do exist demonstrate that psychiatrists, themselves, will misdiagnose 50 percent of the physical, medical illnesses.

This is why it is important not only for psychologists, but also for psychiatrists when traditional medical attention is needed to appropriately refer to the correct practitioner. This is what we do in American Biodyne. We require both our psychologists and our psychiatrists to communicate with the primary care physician of that patient within 48 hours.

The independent practice of psychology has been established in every State and is now a part of just about every medical program in the country except Medicare. Psychiatry has opposed us every step of the way. Being 65 years old, I remember 35 years ago when the medical practice acts were beginning to recognize psychologists State-by-State and I was in the trenches and heard these predic-

tions. And to my knowledge, only one of these "hombles" has come true, it is that when psychiatrists compete with psychologists in the arena, psychiatrists fees are reduced by 8.5 to 12 percent.

Third, and finally in terms of medical input, the physical and psychological problems with the elderly are such that geriatric psychologists and physicians, somewhat more humbled by their experience with patients, recognize the need for each other's expertise and work collaboratively with one another on most cases.

The interdisciplinary treatment approach avoids the pitfall of the present physician-dominated system and permits patients to access the system through whichever provider they prefer rather than letting the limited skill or availability of any profession serve as a barrier to care.

The problem of the present system is the failure of the physician to refer to psychologists, not the vice-versa. The typical healthy Medicare beneficiary sees a physician on the average of 4 to 6 week intervals and psychologists have a record of collaboration.

We have considerable experience, over 35 years of having them oppose our inclusion on our plans and programs. Invariably they distort the training and expertise in an attempt to use their medical prestige to frighten. We will listen to the psychiatric testimony and respond to you in writing, but it would be a cruel perversion of concern to deny our elderly the same right your other constituents have to choose to see a psychologist in their community rather than a psychiatrist or general practitioner just because it is the psychiatrist's considered opinion as to how the world ought to work.

In closing, Mr. Chairman, I would like to give you an example of what I face every day of my practice. Norma was a 79-year-old woman diagnosed to have Alzheimer's disease. The family was preparing to put her in a nursing home. Upon psychological evaluation, it was found that she was taking 28 different medications: 7 of which were prescribed by several psychiatrists.

The psychologist did an evaluation and asked that the patient receive a thorough medical evaluation from her primary care physician. This was done. She was titrated off of all medications except three and within 2 weeks, Norma showed absolutely no symptoms of senility and she was in every respect, sound.

I wish I could tell you that this is a rare and uncommon experience. The elderly in our society are too easily sloughed off by medication or told, "I am sorry, Bill, you are not as young as you used to be. You have to learn to expect these things."

I would like to say that without access to psychologists in many of these areas, these kinds of patients will continue to be misdiagnosed, over-medicated and remanded to nursing homes. Psychologist training enables them to detect chronic brain syndrome and call in medical consultation as appropriate.

I would add that in the programs I have directed in the past 25 years involving several hundred psychologists as well as psychiatrists, and providing services to the elderly, representing over 150 million enrollee months, we have had not a single untoward event or malpractice suit of any kind.

Thank you, Mr. Chairman.

[The statement of Mr. Cummings follow

Statement of Nicholas Cummings, California Psychological Association

Good Afternoon. I am Nicholas Cummings, Ph.D., a Past President of The American Psychological Association and a licensed clinical Psychologist practicing in California. I am the Chief Executive Officer and Co-Chair of American Biodyne, a large mental health care system which serves a significant population of elderly in eight states, including Arizona and Florida. I also administered the first Medicaid HMO contract that was granted to Kaiser Permanente after Title 18 was enacted.

I am here today representing the 8000 licensed psychologists in California asking for your strong support of H.R. 774.

I appreciate Congressman Coyne's leadership and committment to making mental health services more available to our nation's elderly and disabled Medicare beneficiaries through legislative initiatives such as H.R. 774. I also commend the committee for their interest in holding this hearing today.

Amending Medicare law as proposed in H.R. 774 will nearly double the access which the elderly have to mental health services nationally. In California this could mean that seniors will have access to care by 8000 psychologists which they are denied access to at present. Increased access to mental health care is desperately needed by California seniors and the elderly across the nation. In California, only 6% of the elderly population received care through the state mental health system because of serious geographic and physical barriers to care. State officials report that the elderly are the most underserved of any segment of the population.

The elderly have massive unmet mental health need. Unfortunately, when the elderly's needs are addressed at all by physicians, it is often with inappropriate, expensive and sometimes dangerous drug therapy.

The mental health needs of the elderly are well documented. Seniors have a much higher suicide rate than the average for the population as a whole. Seniors face a high rate of depression, anxiety-related disorders and conditions associated with cognitive impairment. The elderly in nursing homes are exposed to some of the worst psychological conditions known, and experience severe loss in every sense of the word. To make life better for them, our current medical system benignly forces them into a state of oblivion through mind-altering psychotropic medications.

The reasons for the needs for mental health services in the elderly population are as varied as in the population as a whole, but several factors contribute to particular need. The elderly are forced to adjust to multiple and severe losses and stresses in greater numbers than other groups. Physical illness and limitations, loss of social network, major changes in living environment, including placement in nursing homes, and death and dying are all common to the elderly. Each of these stresses has a very significant psychological component and each responds well to psychological treatments. In addition to these stresses, inappropriate psychoactive drug therapy is in itself often a significant contributor to physical and mental problems in the elderly - problems which psychological care can ameliorate of alleviate.

Despite this severe need, psychological care is unavailable to many elderly because of Medicare's failure to reimburse for these services, except in certain limited settings - those being rural health clinics and community mental health centers. Far from encouraging the best and cheapest approaches, the present structure of Medicare reimbursement provides unintended perverse incentives in mental health care of the elderly. It is based on

an anachronistic medical model which is costing the system and the beneficiary alike.

This committee should be aware that limiting reimbursement to physicians does not mean that the elderly will receive mental health care only or even primarily from psychiatrists. Assuming, arguendo, that such psychiatric care was appropriate for the elderly, even that care is not what the present system is delivering. Rather, 75% of mental health services delivered to the elderly under the present system are delivered by physicians with no special training in mental health, physicians who have no understanding or expertise in the important psychological techniques which can assist the elderly - in short, providers who are comfortable with few options for dealing with the mental problems of the elderly. Understandably, rates of misdiagnosis of mental disorders among these physicians ranges from 40%-70%. In short, the current system promotes, at best, inaccessibility to mental health care and, at worst, mistreatment of the elderly who have mental health care needs.

Tragically, one of the few options which the great bulk of such providers are comfortable and familiar with is medication, so they use it. The result is physically and psychologically damaging overmedication of the elderly with psychoactive drugs for problems which are often susceptible to more effective and less dangerous forms of psychological treatment. Indeed, overmedication of the elderly has been identified in a recent report by the Inspector General as the nations' "other drug problem." Medicare's reliance upon the medical model of addressing mental health problems to the exclusion of other approaches ensures that this other drug problem will continue to unnecessarily burden the elderly. H.R 774 can change that by opening up effective alternative forms of therapy and care to the elderly.

H.R. 774 builds on Medicare law enacted in OBRA '87. As you may recall, changes made in the '87 OBRA allowed psychological services to be reimbursed when delivered in community mental health centers and rural health clinics. H.R. 774 would simply provide psychologists with the full recognition under Medicare which they already have under all other federal health plans and nearly every private plan existing in the country today. Clearly, current Medicare policy is an anachronism - Unfortunately it is not a harmless anachronism but one with dreadful costs to the mental health of our senior citizens with emotional and psychological difficulties.

PSYCHOLOGISTS' TRAINING AND STANDARDS OF PRACTICE

The qualifications, training and the standard practice of clinical psychology are well established in scientific literature, in a clinical practice throughout the health care industry, and in a broad body of law. As I have mentioned, the federal government recognizes the efficacy of psychological treatment in every other health care program which it operates.

Unfortunately, we are forced to address the misinformation that has been provided to Congress on this issue previously and in this hearing. Disturbing claims and insinuations have been made that quality of care will be jeopardized and the elderly will suffer as a result of allowing psychologists to diagnose and treat the elderly with mental health care needs. Sadly, these claims and insinuations have been made repeatedly by the psychiatric community in state legislatures and courts, and now here. Not only are they unsupported by a single study of the issue, but they are unsupported by so much as a single instance of harm to patients resulting from a deficit in psychological care which a psychiatrist would or could have rectified.

Legislatures are understandably reluctant to involve themselves in "turf battles" among professionals. I do not ask this committee to do so. I do ask that access to care and appropriateness of treatment be the issues in this hearing and in the debate over H.R. 774 - not unsubstantiated claims and misinformation. Attacks on the quality of care provided by psychologists should not be treated seriously. Instead, such attacks should be seen for what they are: remnants of an anachronistic medical monopoly on care which survives today only in the Medicare system, and there to the serious detriment of the nation's elderly.

MEDICAL MANAGEMENT

Appropriate medical management of the elderly is not inconsistent with reimbursement of psychologists. It is argued that there is a need for "medical management" of the elderly, because of increased incidences of physical problems in this age group - physical problems which may cause psychological complications. In fact Medicare does a relatively good job of providing "Medical Management" for the elderly, who see a physician on an average of once every five weeks. Elderly patients receive frequent physical examinations, laboratory work-ups, x-rays and so on by skilled physicians, including internists and other specialists. The issue of adequate medical management of these patients is basically a red herring. The elderly are receiving ample medical care, but little or nothing in the way of mental health care. The real issue is how to ensure that the elderly get more appropriate mental health care. The general physicians providing the bulk of mental health care in this country are simply providing inappropriate, if any, mental health care and are barriers to appropriate mental health services. This hearing should not be about how to more effectively limit access to mental health care but should be about how we can make mental health care more available to those with tremendous needs. H.R. 774 is a very reasonable means to accomplish this goal.

In closing, I would like to discuss in concrete terms the contributions that the profession of psychology and my colleagues have made over the years, with examples from my own practice and experience.

I specifically would like to point to examples of elderly patients who have been erroneously diagnosed and subsequently inappropriately medicated or overmedicated come to us looking like they have agitated senility or Alzheimer's disease. One example of this was a 79 year old female, diagnosed to have Alzheimer's disease. Upon psychological evaluation she was found to be taking 28 different medications -- seven prescribed by several psychiatrists. A psychologist did an evaluation and asked that the patient receive a thorough medical evaluation. The psychologist had the patient removed from all medications except three. Within two weeks, there were no symptoms of senility, and she was, in every respect, sound.

These experiences, especially in rural Indiana and Illinois where there are no psychiatrists, have presented themselves not dozens but hundreds of times. Without access to psychologists in these areas, the patients would have continued to be misdiagnosed, over-medicated and assigned to nursing homes. Psychologists' training enables them to detect chronic brain syndrome and call in medical consultation as appropriate. I would add that in the program that I direct, psychologists have been providing mental health services to the elderly for over 25 years, representing over 150 million enrollee months, without a single untoward event and no malpractice suit of any kind.

Again, I remind the committee of the tremendous and very real unmet mental health needs of our elderly. The elderly are denied access to effective, affordable, and safe mental health care - care from psychologists - by the present restrictions on Medicare reimbursement. H.R. 774 will significantly rectify this situation and I strongly urge the committee to adopt it.

Chairman STARK. Thank you both.

In your testimony, it was indicated that psychologists--I am not sure whether it was psychologists fees, 10 to 15 percent or the aggregate cost of treatment was 10 to 15 percent less, but on which every basis that testimony was derived. Do you feel that psychologists would be willing to accept a fee schedule that would make that the case, that Medicare would be getting services for 10 or 15 percent less than we might under the present psychiatric fees?

Mr. WELCH. I think all the data we have supports that. What I was trying to emphasize in my testimony, the elderly are going to be very dependent upon the availability of lower fee mental health care providers, so as I pointed out with psychologists you have about half of them now that are offering fees for under $80, psychiatrists only about a fourth of them do.

Chairman STARK. I am hearing all the time, any time I talk about getting physicians to accept assignment, in every case, that I will just close off access to seniors by doing that. How would the psychologist respond to the idea of making all of them participating, if in fact we were able to do that under these two bills?

Mr. CUMMINGS. Mr. Chairman, the experience, when California psychologists were enabled under legislation to treat Medicaid patients, they did in act accept a lower assigned fee and have been continuing to accept that lower assigned fee for several years now.

Chairman STARK. Is it your feeling that psychologists would participate, as we call it, and that is take each case at the Medicare approved rate?

Mr. CUMMINGS. Yes, sir.

Chairman STARK. And be able with it? Don't come back and argue next year that it is a question of access?

Mr. WELCH. I promise we won't do that, sir.

Chairman STARK. Let me now, and this is strictly based on some of the testimony and questioning we have heard this morning. It is not in the nature of an amendment, but it is in the nature of seeing what might solve some of the questions here without trying to determine fault in the system.

If there were a requirement that a medical—what is that word? Differential diagnosis or a report by a physician to the psychologist, which might not be a whole differential diagnosis, but just say I have examined this person and I—within, say, a month after the initial visit to the psychologist, not necessarily the second or third, but sometime in the first month, even let's say if they were meeting with them once a week, would be a condition, say, of subsequent payment, so that there is some kind of reference what that would be.

I am sure that would be the source of a lot of argument and discussion, is that something that would concern you? Or do you think that you could live with that kind of a caveat or that kind of language in these bills?

Mr. WELCH. Well, there are a couple of aspects of that that would have to be clarified, Mr. Chairman. If you are talking about collaborative model, collaborative model, if you are talking——

Chairman STARK. Let me tell you what I think I mean, because I can't use all those words. If I am a psychologist and I have a patient who comes to me, a Medicare patient, and I can start treating

that person on my own judgment immediately, and I could treat them for a month, treat them forever if I want, but that unless within a month from the day I start treating this patient as a psychologist, I must either have a report from that person's physician, that patient's medical doctor, or a copy of a form or some other indication that they, and maybe it would have to be within 6 months or something, have had medical treatment or have seen a doctor.

Mr. WELCH. Do you mean that in order to see a psychologist, the elderly person would at some point have to go to a physician?

Chairman STARK. You could talk to a physician. You could talk to that person's physician.

Mr. WELCH. You mean to have the psychologist be required to report the care to the physician?

Chairman STARK. No. What I am trying to say is that a psychologist should be required to consult with a patient's physician to rule out any drug dependency or physical problems that may be causing the mental disorder. Do you understand what I am getting at?

Mr. WELCH. Yes, as I understand it, Mr. Stark, that would be a wonderful proposal. We would be pleased with it and it represents the way psychologists practice now. And I would also hope that you would hear the testimony we are giving with the problem of multiple prescriptions of drugs and take that rule and extend it through the Medicare system as far as you all will go.

Because with all of the treatment that the elderly are getting, they see a physician now on average, a healthy Medicare beneficiary sees a physician every 6 weeks. Average health, they see them every 4 weeks. So they are going off in all kinds of directions.

I think the plan that you are describing would be the model plan that we would be happy to endorse. I would encourage you to go across the board with that. That is what I was calling collaborative.

Chairman STARK. I thought you meant you had to be partners with a doctor.

Mr. WELCH. No, no, not a joint venture.

Chairman STARK. OK.

Mr. Gradison.

Mr. GRADISON. Thank you, Mr. Chairman. I have been surprised, pleasantly surprised, by the relatively modest cost estimate that we have received with regard to this proposal. I believe it is in the order of $10 million. While it is a lot of money, it is a very small amount for an additional service compared with some of the estimates we have received in the past for other potential add-ons.

Why is it so low? Or, does it sound right to you?

Mr. WELCH. The figures that were used from CBO do sound accurate to us. I think that it is important to recall that CBO did not allow for any type of medical cost offsets. So we have had the study checked. We had Peat Marwick do a study to collaborate it.

They concluded that that was a realistic estimate. We also had a health economist from Boston University do an evaluation of it and he came up with very comparable figures. So we have gone to a great deal of trouble to make sure that those are reliable figures so we could argue to you that it is a cost-effective proposal.

Mr. GRADISON. Would it be possible for you to share with us the conclusions that you received from Peat Marwick and the other studies?

Mr. WELCH. Yes. We would be glad to give you the report.
Mr. GRADISON. It would be helpful. Thank you, Mr. Chairman.
[The information requested follows:]

American Psychological Association
Advancing psychology as a science, a profession, and as a means of promoting human welfare

March 18, 1989

The Honorable Willis Gradison
United States Congress
2311 Rayburn House Office Bldg.
Washington, DC 20515

Dear Congressman Gradison:

This is in response to your request during the hearing before the House Ways and Means Health Subcommittee on the subject of Mental Health Needs of Older Adults and H.R. 774, on March 6, 1989.

Enclosed is a study prepared by KPMG Peat Marwick on the federal budgetary implications of including psychologists among the list of eligible Medicare providers for outpatient mental health benefits.

Thank you very much for your interest in this study. Please do not hesitate to contact our office if we can be of further assistance to you in this or any other issue of concern to our nation's citizens.

Sincerely,

Bryant Welch

Bryant L. Welch, J.D., Ph.D.
Executive Director for
Professional Practice

1200 Seventeenth Street, NW
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March 17, 1989

Memorandum for: Ms. Donna Daley
American Psychological Association
1200 Seventeenth Street, N.W.
Washington, D.C. 20036

Prepared by: The Policy Economics Group
KPMG Peat Marwick

This memorandum presents a summary of the Policy Economics Group's analysis of the Federal budgetary implications of including psychologists among the list of eligible Medicare providers for outpatient mental health benefits.

The approach that was adopted for this effort was to review the Congressional Budget Office estimates of the budgetary effects of the eligibility expansion and other previous research in this area. On the basis of this review we assessed certain factors that could cause the CBO estimates to be higher or lower than currently estimated.

The general conclusion that emerges from the analysis is that the CBO methodology for estimating the effect of the expanded eligibility is sound overall. However, CBO acknowledges that they do not include in their estimates a potential offset for lower medical care utilization; this offset could be quite large and could in fact even fully offset the direct effects of the eligibility expansion.

I. Assessment of CBO Analysis

Background

On May 31, 1988, CBO submitted an estimate of the effect of amending Title XVIII of the Social Security Act to include the services of psychologists under Part B of the Medicare program. This analysis estimated an increase in Medicare outlays of $10 million in FY 1989, $15 million in 1990, and %25 million in FY 1992 and FY 1993.

A recently released update of these estimates shows annual costs of $30 million in 1993 and $32 million in 1994.

Methodology

The CBO methodology for estimating the federal budgetary effects of the proposed Medicare expansion appears to have three major elements:

(1) The direct budgetary effect of covering the costs of psychologists services currently being provided to Part B beneficiaries and being paid for by the recipient or private insurers. In effect, costs are shifted to Medicare from other payment sources.

(2) The effect of covering the costs of additional utilization of psychologists services induced by the Medicare coverage. From an economic perspective, this induced utilization occurs because the effective price of the service has been reduced for the aged recipients.

(3) The effect of the expanded coverage on the costs per user. This effect could be expected to include: (a) a lower average cost due to substitution of psychologists services for comparable services currently provided by higher price psychiatrists; and (b) lower prices by psychiatrists as a result of increased competition.

Direct Caseload Increase: The direct effect of expanding medicare coverage to include psychologists is estimated in the literature to increase the Medicare caseload for outpatient mental health by approximately 5 percent, or, at 1994 beneficiary levels, by about 50,000. This estimate is consistent with estimates produced by Dr. Thomas McGuire of Boston University. Dr. McGuire estimated that including psychologists as eligible providers would directly increase Medicare beneficiary levels by as much as 5 percent.

Induced Caseload Increase: CBO's estimate of the induced increase in the mental health care caseload appears to be derived from a statistical relationship that specifies the percentage of Medicare enrollees who use outpatient mental health benefits -- estimated on a state-by-state basis -- as a function of economic, demographic, and provider-related influences. The provider variable is defined as the number of psychiatrists per thousand Medicare enrollees. Defining psychologists as eligible providers allows new values for the provider variable to be inserted, and correspondingly new percentage use values to be obtained. Although CBO has not yet published detailed assumptions underlying their estimates, it would appear that the induced increase in beneficiary levels would reach approximately 200,000 by 1994.

Reduced Costs Per User: As noted above, including psychologists as eligible providers will reduce the estimated cost per user because of the substitution of lower priced psychologists services for those of psychiatrists and the likely effect of increased competition on psychiatrists' fees. The CBO methodology does appear to adequately account for these effects, reducing average costs by between 5 and 10 percent relative to a base case cost per user growth rate over the 1990-1994 timeframe. This appears to be reasonable, though it is important to note that there is little literature or empirical evidence on which to base this offset estimate.

Based on the assumptions described above, it would appear that the 1994 CBO estimate of the effect of expanding Medicare coverage to psychologists can be disaggregated as follows:

	Budgetary Cost (millions of dollars)
New Medicare beneficiaries	+42 to +47
Reduced costs per user	-10 to -15
Net budgetary cost	32

The CBO methodology and assumptions generally appear to be quite reasonable. The one potential gap in the analysis is that it does not take into account the potential offsetting effect of reduced utilization of medical services that might reasonably be expected in response to greater use of mental health care services.

II. Analysis of Major Cost Factors

The Medical Cost Offset

The professional literature related to the impact of ambulatory psychotherapy on other medical care utilization strongly suggests that any increase in the utilization of mental health care services by the aged could be expected to have as a mirror image reduced utilization of medical care services by the aged. The literature suggests that the reduction in medical care services could be 15 to 20 percent of the medical costs normally incurred by the aged recipients of psychotherapy services. 1/

For purposes of estimating the potential offset from reduced utilization of medical care services, we have made the highly conservative assumption that medical care costs are reduced by only 5 percent -- which is only a third to a quarter of the effect generally estimated in the literature. The estimated 5 percent cost offset is applicable to the induced increase in users of psychotherapy services that could be anticipated as a result of the Medicare coverage expansion. As discussed above, the induced beneficiary increase is estimated to be approximately 200,000 by 1994.

The average level of medical care expenses paid by Medicare in 1994 was estimated to be $1,866. This is the estimated Part B per enrollee expenditure for disabled enrollees, as estimated by the Health Care Finance Administration (HCFA). Although disabled enrollees are disproportionate users of mental health care services, their expenditures per enrollee are lower than those for the aged under Part B. The use of this assumption is therefore conservative. Applying the 5 percent reduction to the $1,866 cost estimate produces an estimated medical cost offset of $93 per beneficiary.

Applying the $93 per beneficiary to the estimated 200,000 new users of psychotherapy produces an estimated offset of $19 million, or nearly two thirds of the estimated cost of the medicare coverage expansion when this effect is excluded. It is interesting to note, moreover, that if a cost offset of 10 percent is assumed, which is again conservative relative to the offsets reported in the literature, the Medicare expansion to cover psychologists would actually reduce overall budgetary costs.

Furthermore, these estimates do <u>not</u> include other potential Medicare cost offsets related to reductions in impatient psychiatric utilization resulting from expanded access to outpatient mental health services.

<u>The Direct Caseload Increase</u>

The estimates presented earlier assumed a direct caseload increase of 5 percent due to expansion of medicare coverage. As previously noted, this estimate is consistent with the professional literature on this subject.

In our review, we noted that of the approximately 700,000 current outpatient mental health users under Part B, approximately 420,000 are disabled, with the remainder representing aged enrollees. Given this composition of the current patient workload, and the economic circumstances of the disabled, we believe that a direct enrollment impact of less than 5 percent could in fact occur. Suppose that a more appropriate estimate is 5 percent of aged recipients, but only 2 percent of disabled recipients. In that case, there would only be a 3 percent direct caseload increase on an overall weighted average basis. This would reduce further the estimated annual cost of expanded provider coverage. If the direct enrollment impact were in fact only 3 percent, the estimated annual cost of expanding Medicare coverage would be further reduced.

An Alternative Estimate

The "base" estimate of the incremental cost of expanding Medicare coverage to include services provided by psychologists, as shown previously, is approximately $30 million at 1994 program levels. If a 5 percent offset is assumed for reduced utilization of medical care services, this estimated is reduced by $19 million -- to only $11 million. If it is further assumed, as seems potentially plausible, that the direct enrollment impact is only 3 percent instead of 5 percent, a further reduce of approximately $2 million is estimated, reducing the total impact of the expanded coverage to less than $10 million.

	(in millions)
"Base" estimate of budgetary impact	$+32
Potential offsets:	
Medical cost offset	-19
Lower estimate of direct enrollment	-2
Alternative estimate of budgetary impact	$+11

1/ Jones, K.R., Vischi, T.R. (1979). Impact of alcohol, drug abuse, and mental health treatment on medical care utilization: A review of the literature. Rockville, MD: Alcohol, Drug Abuse and Mental Health Administration; and Mumford, E., Schlesinger, H.J , Glass, G.V., Patrick, C., & Cuerdon, T. (1984). A new look at evidence about reduced cost of medical utilization following mental health treatment. American Journal of Psychiatry, 141, 1145-1158.

Chairman STARK. Mr. Levin.

Mr. LEVIN. Thank you, Mr. Chairman. I think that your question was a $64 million question, and I was glad for the answer. So I don't have any other questions except one.

I think we have been trying to zero in on the key issues here this afternoon. In your testimony you say that 75—between 75 and 85 percent of all mental health services received do not come from a mental health professional, but instead are rendered by general physicians who typically have less than 3 months of mental health training.

And then there is a reference there. Are those data conclusive? Can we go around and say that between 75 and 85 percent of the mental health care——

Mr. WELCH. That virtue is reported in a number of different studies, Mr. Levin. We believe it is reliable. And I think we have supplied copies of it to your office, the actual studies, if we have not we will be glad to do so.

Mr. LEVIN. By the way, do you advocate that we limit this extension? One reason the figures are so low from CBO, I think, is because the benefit itself remains rather restrictive with the copayments, and deductibles we have. We are dealing with a pretty low ceiling, and it takes a lot to push it up, if you know what I mean.

But anyway, you suggested we limit this to psychologists, the extension?

Mr. WELCH. No, sir, we are not suggesting that, and we believe that it is important that the entire country have complete access to the mental health care delivery system.

Mr. LEVIN. So it is broader than your position. You are here representing the association, right?

Mr. WELCH. Yes, sir.

Mr. LEVIN. And your position is in favor of inclusion of other professionals within——

Mr. WELCH. The issue that we are advocating is to include psychologists. I certainly would not recommend against including social workers or psychiatric nurses. Many of them provide very important services as well. The argument that we always encounter is that if we let psychologists in then we will have to let everyone else in.

That does not seem to me to be a valid intellectual argument. So we don't accept the argument if you have just a little bit of money, you can't let the psychologists in because then you would have to let everyone else in.

If you have funds to pay for it, we would certainly support your inclusion of other provider groups and we are not saying pay us, but don't pay our competitors. Am I being clear on that?

Mr. LEVIN. I think that you are saying that you think that psychologists should be included if there is additional money. We should go beyond that?

Mr. WELCH. Yes, sir.

Mr. LEVIN. Thank you.

Chairman STARK. Mrs. Johnson.

Mrs. JOHNSON. Thank you very much. I think the chairman asked the key question and I just want you to give some additional thought to refining it with us in the weeks ahead. It is easy enough

for us to write the language that would allow coverage during the first month of care, but what happens at that time?

What should be required and what would be the triggers? Do you require reports by the psychologist to the primary physician? What will be the frequency of those reports? At what point would reimbursements be cut off? Or would it simply be a matter of notifying the patient formally that they should have a physical?

Should the Government take a stand and say if you don't follow the psychologist's advice and go to the doctor, we stop reimbursements? Should we say that if a psychologist doesn't refer you to a physician for a physical, the eligibility will stop? So those are the kinds of issues I wish you would consider.

Mr. WELCH. I thought that Mr. Stark was really, I think the wording, verbatim, is, "What I was very enthusiastically endorsing." And I hope he wrote the legislation, and I am glad we have a stenographer here because I don't think I could recapture it.

But that language is perfect. Earlier you mentioned your mother who would not want to go to a psychiatrist. Our concern is that we not handicap care here so that your mother, who might be more comfortable going to a psychologist will then be told in order to get in the door for her sleep disorder because she doesn't want to be addicted to it, that she will have to get a physical examination and be put through all manner of demands just to deal with the hypothetical possibility that there is some organic disorder when she has been seeing a doctor for the last 5 years once a month.

That is the kind of situation I am trying to avoid. So I thought what Mr. Stark was talking about, the formula where the—it is a collaborative model, as I understand it, where the psychologist would tell the general physician that the person has come for this disorder. The general physician has seen them in the last 6 weeks or knows that it is a safe procedure, then there is no problem.

If it is something where the general physician has been treating them for a couple of conditions of comorbidities where there is a question of new medical diagnosis, the patient would be called in. That is a collaborative model I am talking about. Again, I would emphasize you do it throughout the Medicare system and I think that it is a very good system.

Mrs. JOHNSON. So that your interpretation of the chairman's comments is that psychological care would be eligible for Medicare reimbursements so long as at least by the end of the first month the primary care physician had been advised.

Mr. WELCH. I am saying to you very strongly that psychologists are well-trained to know when the condition for which they are treating the elderly begins to raise problems that require other medical complexities. So on an ongoing basis, yes, they are well-qualified to do that.

Mrs. JOHNSON. My concern is that as the issue of collaborative relationship is developed either in the law or in regulations, it would make it impossible for you to stay at the level of reimbursement——

Mr. WELCH. I share that concern.

Mrs. JOHNSON. I think it is important that we not allow the concept of collaboration to spin itself out there into some very elabo-

rate and paperwork, heavy-documented relationship because we will undercut the goal, I think, if we allow that to happen.

I just want to be careful and that we have a very clear idea at some point on the record what we intend.

Mr. WELCH. I would like to ask that there be one other sensitivity, too. It is very important that we not dismantle the whole mental health system here in the process. There is no question from the psychiatric literature that they are casting about for some way to require everyone to go through them before they see the other mental health professions.

Social work and psychiatric nursing and psychologists are providing a major role in mental health care. So I hope that you won't accidentally create a model that will be carried over into the other States and you will be seen as recommending that you need medical screening, medical oversight and so on, when you have no data to indicate that you need it, and in fact you have psychologists providing very safe and high quality service now. So that is a concern that we have in this kind of issue.

Mrs. JOHNSON. Thank you.

Chairman STARK. Mr. Moody.

Mr. MOODY. It has been a very good testimony and I appreciate your testimony. No questions.

Mr. Chairman, I would like, however, to ask unanimous consent to include in the record some comments I have.

Chairman STARK. Without objection.

[The information follows:]

STATEMENT OF REP. JIM MOODY
ON H.R. 774

Subcommittee on Health
Monday, March 6, 1989

Mr. Chairman, thank you for holding today's hearing on H.R. 774, legislation sponsored by our colleague Rep. Bill Coyne to authorize direct reimbursement of psychologists under Medicare.

The mental health needs of the elderly are serious and pervasive. There is also no doubt that those needs are not being fully met today. As many as 25% of today's elderly require some form of mental health therapy, yet estimates suggest that only half of these are receiving adequate attention for their mental health needs.

First, there are access problems. Many of those elderly needing mental health counselling and treatment simply do not live within a reasonable distance of a psychiatrist.

Second, there is also a serious question about the appropriateness of care many of the elderly are now receiving. I suspect that without the Coyne bill, we would agree that it is most appropriate under today's Medicare payment regime for psychiatrists to be the primary deliverers of mental health care for senior citizens. But in fact it is the case that most mental health treatment of seniors is delivered today by general practitioners who have little or no training in psychotherapy, or in the appropriate use of psychotherapeutic medication. This in turn can have tragic results.

A series of articles published in last summer's Arizona Republic documents in detail the gross over-application of medication of the elderly. Although the medical profession is surely unhappy with the practices documented in this series, it seems clear that the particular requirements of geriatric medicine, and of geriatric psychotherapy, are simply not being adequately met by the medical profession today.

As the series in the Arizona Republic noted, "many elderly who do suffer from mental health problems are not being treated with psychotherapy . . . as are their younger counterparts but are instead only being given psychoactive drugs." The series goes on to say that "most of the antipsychotic medication given to elderly nursing home patients have been ordered not by mental health experts, but by internists and family practice physicians." I am submitting an excerpt of the Arizona Repbulic series, dated June 26, 1988, for the Subcommittee's interest.

So we have an overlapping series of problems: the elderly are not receiving the mental health care many of them need, and those who do receive it are often receiving the wrong treatment.

The Coyne bill won't solve all of the problems in mental health treatment of the elderly. But it is a major step in improving access to care for those elderly who can't now get it. And I hope that it will also lead to an improvement in the quality of care now being received. I am glad to be a cosponsor of the bill, and I commend my colleague for introducing it.

SPECIAL REPORT/ DRUGGING OUR ELDERLY

"Drugs do . . . quiet them down. So does a lead pipe to the head." — Dr. Jerome Avorn

Mentally sound given psychoactive drugs

By Mike Masterson and Chuck Cook
The Arizona Republic

Many elderly people confined to institutions and care homes have been shackled to their beds by prescription drugs so powerful they have been used to torture Russian dissidents and have been linked with sudden and unexplained deaths.

The potent and effective antipsychotic medications have deceptively soothing names like Mellaril, Navane, Prolixin, Stelazine and Haldol. But when they are misused on mentally sound elderly people primarily to control their behavior, they can cause debilitation and death.

In a report released this year, Drs. Meyer D. Glantz and Michael S. Backenheimer of the National Institute on Drug Abuse scolded doctors who misuse such drugs, accusing them of "elderly drug abuse."

Numbers of elderly who do not suffer from a mental-health problem are being given psychoactive (antipsychotic) drugs for reasons that cannot be justified, they wrote.

"Many elderly who do suffer from mental-health problems are not being treated with psychotherapy . . . as are their younger counterparts but are instead only being given psychoactive drugs," the report said.

"We consider this to be elderly drug abuse perpetrated by the prescribing physicians."

Dr. Jerome Avorn, an associate professor of social medicine and director of the program for the Analysis of Clinical Strategies at Harvard University, said his studies also show elderly men and women have been inappropriately medicated with these antipsychotics, which are also major tranquilizers.

"Drugs do work. They do quiet them down. So does a lead pipe to the head," Avorn said.

Avorn has discovered that while drugs are indeed beneficial for many, far fewer medications and alternatives to the powerful medications often are preferable for the elderly.

In many instances, antipsychotics produce side effects that imitate ailments associated with aging such as Alzheimer's and Parkinson's diseases.

Tom Rogers/The Arizona Republic

George Debose, who has Alzheimer's disease, is visited by his daughter Anise at a Washington, D.C., hospital. He was overdrugged with antipsychotics at a nursing home, his daughter said.

Misuse of these medications has needlessly caused elderly men and women to end their lives in quivering stupors and has hastened the deaths of thousands.

Among the elderly victims of mismedication with mind-altering drugs discovered are:

- Carl Hartman, 82, of Sun City, who lapsed into a coma, then died after being given 10 times his prescribed sleeping medication.
- Gertrude Mayer, 89, of Chicago, who sought new friends but found death after she broke her hip while under prescribed antipsychotic medication in a nursing home.
- Cecile Howsman, 85, of Florida, whose daughter said she became "a vegetable" after a nursing-home staff gave her 300 times the original prescribed dosage of a powerful tranquilizer.

The Soviets for years controlled dissidents by drugging them with Haldol (generically haloperidol).

The extent of the misuse of antipsychotics and other mind-altering drugs in the United States is documented in data from the National Disease and Therapeutic Index.

Although they make up only about 11 percent of the population, NDTI statistics for 1985 show adults 60 years and older use more than a third of all antipsychotic drugs and major tranquilizers.

"This level of psychoactive drug prescribing is very highly disproportionate for this age group's representation in the population and very highly disproportionate for their reported prevalence of mental-health problems," Glantz and Backenheimer concluded in their report.

While the elderly have been given the biggest portion of these medications, researchers found it has not necessarily been of their choosing.

For example, a 1986 study found that 63 percent of the elderly surveyed expressed "very unfavorable attitudes" toward using such tranquilizers. They, more than any other age group, felt they did not need or want these drugs, that study determined.

Another 1986 study of 2,000 pharmacies and millions of prescriptions written nationwide found that 60.5 percent of the drugs prescribed for nursing-home residents over 65 were for the major tranquilizers and 17.1 percent were for minor tranquilizers.

Dr. Theodore Reiff, professor of medicine at Eastern Virginia Medical School in Norfolk, Va., said many aged Americans with emotional disorders — who respond well to psychotherapy — get drugs instead of counseling, because in such cases Medicare reimburses only 63 percent of a psychiatrist's "reasonable fees," up to a maximum of $312.50 each year.

In contrast, Reiff said, Medicare reimburses other types of medical care at 80 percent with no maximum.

"This is an immense problem because hundreds of thousands of older persons are being treated inappropriately," he said.

Dr. Terry Kupers, a psychiatrist and geriatric specialist from Oakland, Calif., and a professor at the Wright Institute in Berkeley, said the disparity in treatment is most evident among the elderly.

"There is no place in society for the elderly neglected except nursing homes or hospitals," he said.

The staff of many nursing homes have no way to provide meaning in life, Kupers said.

Dr. Walter Nieri, a Phoenix internist and board member of the Maricopa County Medical Society, also agreed the use of antipsychotic drugs on the elderly has been a known problem. But he sees some hope ahead as the abuse of such medicine is more closely scrutinized by the public.

"Now, more than ever, efforts are being made to limit the use of psychotropic drugs," he said. "This is obviously good news for the elderly."

But those efforts would be too late for the thousands who already have suffered from misuse.

In addition to obvious adverse reactions, these drugs produce side effects that masquerade as other diseases and therefore, "often go unnoticed," said Dr. William Samonson, associate professor of pharmacy at Oregon State University.

"Many health professionals have a mistaken attitude about the elderly patient that perpetuates . . . the unfair 'elderly stereotype,'" Samonson said in a March testimony before the Senate Special Committee on Aging.

The stereotypical ailments of the aged cited by Samonson include confusion, depression, weakness, tremor, constipation, diarrhea or urinary retention, all of which are often caused by mismedication rather than disease.

The antipsychotics can effectively control the behavior of older people, especially those living in some of the nation's 20,000 nursing homes.

These potent drugs have been administered at will to many aged by the staffs of some nursing homes where doctors allow them to be given "as needed." Medical specialists agreed that it costs far less to supply an assertive older person with such pills than to pay the salary for a counselor or program director.

A University of Connecticut survey of 306 non-institutionalized elderly clients found they were collectively using over 275 different generic drugs, and more than half of those were receiving mood- and mood-altering medications, largely Valium.

Dr. Frederick Zugibe, the chief medical examiner for Rockland County, N.Y., said wrongly prescribing Valium (a Benzodiazepine) to an older person who is mentally depressed often only intensifies that condition and can lead to suicide.

"I've even seen patients in my role as a medical doctor... come in with severe depression, right near the brink, and I say, 'Oh, My God, the doctor put you on Valium!' — the worst thing he could have ever done'," Zugibe said.

Most of the antipsychotic medications given to elderly nursing-home patients have been ordered, not by mental-health experts, but by internists and family practice physicians.

The doctors prescribe these drugs for anxiety, depression and psychosis "without the benefit of psychiatric consultation," according to Milton Mosconitz, a Maryland pharmacist who presented those findings to the National Foundation for Long Term Health Care in Washington, D.C.

Chairman STARK. Mr. Pickle.

Mr. PICKLE. I would ask you gentlemen, Dr. Cummings, you related an example of a 79-year-old lady who had taken 28 different kinds of medicines when she was evaluated by a psychologist. How did the psychologist get in that act?

How did he get authorized to get into the picture if seven or eight different physicians, psychiatrists had been prescribing medicines for her?

Mr. CUMMINGS. The psychologist saw Norma, the 79-year-old woman, because American Biodyne came into the picture.

Mr. PICKLE. Came into the area?

Mr. CUMMINGS. The area of Rockford, Ill. American Biodyne is the mental health at-risk company that I am CO of that is in eight States now. It covers a very significant population of elderly.

Mr. PICKLE. I am not familiar with the organization that you mentioned, but someone had authority to refer that patient to a psychologist? Who was that? Who was that person or group?

Mr. CUMMINGS. Her primary care physician.

Mr. PICKLE. Say it once more.

Mr. CUMMINGS. The primary care physician.

Mr. PICKLE. And the physician called them in?

Mr. CUMMINGS. Referred Norma for an evaluation of her delirium.

Mr. PICKLE. In your practice how many times have psychiatrists referred patients to you?

Mr. CUMMINGS. How many times? I would have difficulty in saying after 35 years of practice.

Mr. PICKLE. Well, of course I don't want the exact number. Is it a very small number or very seldom or practically never?

Mr. CUMMINGS. I think that psychiatrists do refer, not in the same number as general practitioner physicians or family practicing physicians.

Mr. PICKLE. I am not getting an answer. I am trying to establish the fact that very seldom do psychologists get brought into these evaluations. Is that generally correct?

Mr. CUMMINGS. Very seldom are they brought in until the patient has demonstrated symptoms of severity that an alarm has gone off and the primary care physician referred Norma prior to the family's remanding her to a nursing home.

Mr. PICKLE. Well, they could be referred to psychologists on a private basis, I presume, but not under Medicare? That is the general practice now.

Mr. CUMMINGS. Yes.

Mr. PICKLE. But this 79-year-old lady was referred by a physician that came through that?

Mr. CUMMINGS. Yes.

Mr. PICKLE. I would think that the cost of $10 million is very, very small and probably underestimated. I would imagine if you had direct reimbursement that might just zoom way up there. I don't—I am not satisfied with the present system. I am not asking myself, how do we control you?

I understand that CHAMPUS has a program that provides for a third party referral. Are you familiar with that program?

Mr. CUMMINGS. Moderately so. Yes.

Mr. WELCH. I am quite familiar with it, Mr. Pickle.

Mr. PICKLE. How does it work?

Mr. WELCH. I think you are talking about the new managed care system under the CHAMPUS reform initiative. CHAMPUS has two systems. The vast majority of health care under CHAMPUS is still provided under the traditional system where patients are perfectly free to go directly to a psychologist or to a psychiatrist, as they prefer. That is the way that about 97 percent of CHAMPUS beneficiaries are currently being treated.

They don't need a referral. They have free access. There is a manager care system that has been set up in Tidewater and in San Diego in which they are using gate-keeper mental health providers. They are psychologists, psychiatrists, social workers and nurses who are first screening the patients who want mental health care and then they refer them out into the community.

It is not something where they are required to get a medical screen. They are systematically required to be seen by a case manager who could be a psychologist, psychiatrist, or nurse. So that is the system I believe you are referring to.

Mr. PICKLE. I haven't read enough about the CHAMPUS approach and it may be an approach that we could look into. I wish you would concern yourself about that approach also, either one of you or your associations. I think what we are looking for is a way that we can appropriately make these referrals and I think if you don't have some way to handle it differently, the cost would go sky high.

And then there are five or six other groups out there who want the same reimbursement, and you can't blame them. But this year we are talking about psychology.

Mr. WELCH. We have quite a bit of literature on it. We would be happy to talk with you about it. Let me also say in response to your question about cost, I think the cost estimate really overstates the net cost to Medicare. Keep in mind that studies show when people get access to psychological care it reduces their subsequent medical utilization and Dr. Cummings was one of the pioneers in that respect.

And that is not allowed for or accounted for in the CBO estimate.

Mr. PICKLE. I am sure that that would be factual. I don't dispute it. I could almost use the same comparison. It will bring more money back into the Treasury. We here that all the time, but I don't compare that to what you just said. It is a fact that we are trying to establish. Thank you, Mr. Chairman.

Chairman STARK. Thank you. I want to thank the witnesses for their participation today and look forward to working with you on this issue in the future.

Now, we come to Dr. Melvin Sabshin, who is the medical director of the American Psychiatric Association.

STATEMENT OF MELVIN SABSHIN, M.D., MEDICAL DIRECTOR, AMERICAN PSYCHIATRIC ASSOCIATION, ACCOMPANIED BY JOHN HAMILTON, M.D., DEPUTY MEDICAL DIRECTOR, AMERICAN PSYCHIATRIC ASSOCIATION

Dr. SABSHIN. Mr. Chairman, I would like to thank you and members of the subcommittee for permitting us to testify today. I am the medical director of the American Psychiatric Association (APA), a medical speciality society representing over 35,000 psychiatrists in this country.

I am a former dean of a medical school and have devoted a large part of my career to the education of psychiatrists and other physicians. I am accompanied today by Dr. John Hamilton, a deputy medical director of the APA who is in charge of our clinical psychiatric services; he is also in charge of a program of quality assurance that he handle for CHAMPUS.

To the point that Representative Levin and Representative Pickle made earlier about quality assurance work under CHAMPUS, Dr. Hamilton is one of the country's experts on accomplishing CHAMPUS quality assurance. I have submitted my written testimony. I hope it can be included in the record.

Chairman STARK. Without objection, Doctor, it will.

Dr. SABSHIN. What I would like to do is to make some summary comments focusing on the needs of patients in regard to quality medical care, access to mental health services and some comments about cost of care.

Mr. Chairman, may I ask you to convey our best to Representative Coyne. We are sorry he isn't here. I am very pleased that in recent weeks he has had the opportunity to go to the University of Pittsburgh to see its modern psychiatric training and research program. And he has seen the new psychiatry.

Chairman STARK. I will, and I understand the weather and the travel jams have slowed him down in getting here. I anticipated that he would be here by now. But as the author of this bill on the House side, he is to be commended and you are quite right. It is with his able assistance that we have been able to move along to this point. So I will certainly pass your greetings on to him.

Dr. SABSHIN. Thank you, sir. In this testimony, we are ultimately going to make two recommendations for your consideration. First, as you look at relevant alternatives, we hope you consider other alternatives such as reducing the copayment costs for the Medicare patients, which are still at the 50 percent level, rather than the 20 percent level as for other medical disorders.

We hope you will consider that and at the same time we hope that you will consider that the options, vis-a-vis a medical differential diagnosis and a medical plan for treatment as you have been discussing already, are looked at carefully.

We feel confident that you will do that. At this point, I would like to just read two sentences and elaborate on them, if I might. "Only a physician is authorized to render a diagnosis concerning a mental disorder organic in origin or nature. Psychologists cannot make a medical diagnosis or devise and implement a treatment plan utilizing such means since these matters are not consistent with their scope of licensing."

Those two sentences are not from any briefs or statements of the American Psychiatric Association but come from the California Court of Appeals in the *Capp* v. *Rank* decision of June 1988. We recommend you read that decision. We believe it is of great concern to psychologists at this point in history because there appears to be a growing awareness by decisionmakers about the difference between psychologists and psychiatrists, and to the extent those differences are understood, I think our position will be adopted.

In the *Capp* v. *Rank* decision, it says if psychologists are given the discretion to admit their patients to a facility and to give nonmedical treatment without the supervision of a physician, then the patient's health may be at risk. I will make a few comments relative to that.

I think their response—American Psychological Association—to the decision is flawed in one serious fashion. There is a flaw in their appraisal of medical school education itself. The training in anatomy, physiology, biochemistry, pathology, and pharmacology are not divorced from the realities of mental health or psychiatric care. They are part of the interaction of body and mind.

The testimony you just heard is peculiar in that it states that we teach psychologists about organic causes of illness but the training in medical school is essentially unimportant and all the medical students only get about 3 months of mental health training. The removal of all the basic sciences and other clinical experiences is flawed.

In addition, you also heard some statements about comorbidity. There is an intermingling of physical and mental disorders. I remind you, Dr. Alzheimer was a psychiatrist.

There is a drug-related response to medication for cancer or other diseases which might cause depression or other reactions. In effect, the psychiatrist, from our perspective, is the one who makes this broad-based examination.

There is a new profession of geriatric psychiatry and we are pleased that the American Board of Psychiatry and Neurology has acknowledged this as a subspeciality.

The psychiatrist is the individual best trained to make the diagnosis that you talked about. In this case the combination of the internist and the psychologist is not the same.

Furthermore, the very act of making a choice of when to seek a consultation and who to consult is not such a simple mechanical point. Knowing who to choose under what circumstances takes some skill. Especially in these days of the complex interaction of patients often having many different doctors, the system itself has problems. But at best it needs to be someone who can understand the interaction of the body systems and drugs, and we think the psychiatrist is in the best position to make a differential diagnosis.

We argue strongly that before one starts treatment, there ought to be a diagnosis. You have been discussing the point of when should a diagnosis be made. It should be made before the treatment starts. With the elderly the combination of physical and mental overlapping conditions and their interactions needs to be made before the direct treatment can be prescribed.

In the testimony you just heard, there has been a strong statement about overutilization of drugs, but you need to be aware that

there is a very strong effort on the part of psychologists to seek prescription privileges simultaneously. There are some contradictions in that point.

As to access to treatment, I think there are some shortages, as Senator Rockefeller said. Nationally, about 62 percent of counties don't have a psychiatrist. At the same time, looking at aggregate populations, only 14 percent of the U.S. population and 16.6 percent of the population over age 65 reside in counties without a psychiatrist. In the overwhelming number of cases, there is a psychiatrist.

I am still concerned about the area of shortage, but the access will not be improved very much by the availability of psychologists because, of the counties without psychiatrists, only one in five has a psychologist. In each of these counties there are physicians. So from an access standpoint, it would be more relevant to increase the general physician's capability of making the initial appraisal, rather than seek the psychologist as the person being seen first.

This piece of legislation will not solve the access problem. It is much more complicated than that.

In the matter of costs, I hope you understand that the basic access problems for older people and for those who are seriously disabled under the Medicare system is that discrimination still exists against these patients.

We heard the comments about stigma and that disturbed me, because this stigma still exists. Gradually it is decreasing, but it will be a long time before it is gone. All we can do with legislation to reduce the impact of stigma will be good. But the access will be increased when the stigma is reduced and the copayment is increased.

Misdiagnosis occurs by psychologists and certainly it occurs with a variety of physicians, too. But at the same time, I do want to stress that if one insists on every patient having a physician, preferably a psychiatrist, to make a diagnosis then there may be few problems in having every patient appropriately referred.

I say to you that I hope you will give serious attention to the matter of looking at alternatives, including reduction of copayment.

I hope also that we can go into the matter of a medical differential diagnosis and a medical plan for treatment, and we look forward to discussing this with you because we know you will give serious consideration to that.

Thank you.

[The prepared statement of Dr. Sabshin follows:]

Statement of Melvin Sabshin, M.D., American Psychiatric Association

Mr. Chairman, I am Melvin Sabshin, M.D., Medical Director of the American Psychiatric Association, a medical specialty society representing more than 35,000 psychiatrists nationwide. I am pleased to appear before you today to offer testimony on the issues related to provision of mental health services under the Medicare program and on HR 774, legislation to expand psychologists' direct reimbursement under the Medicare program. My own career has involved management, teaching, research and direct patient care. In my capacity as Dean of a School of Medicine, I was given the opportunity to oversee the education of future physicians, and I am intimately familiar with the differences in education and training of physicians and nonphysicians.

My testimony addresses three substantive areas and suggests for your consideration legislative amendments to Representative Coyne's bill, H.R. 774. Substantively, I will review for you: the quality of care necessary for patients with mental disorders; an independent study of access to mental health care; and cost of care issues.

At the outset, I would want Representative Coyne and the Committee to know we appreciate the time Mr. Coyne has given to hearing our views not only in meeting Pennsylvanian's, Dr. Paul Fink, APA's President, and a Pittsburgh constituent geropsychiatrist; but also through a site visit to a geropsychiatry unit at Western Psychiatric Institute and Clinic, and in meeting with psychiatrists and other geriatricians at both the Western Psychiatric Institute and Clinic and the Benedum Geriatric Clinic.

Quality of Care

The issue of delivery of quality mental health and other health care has many important determinates with the most important being the education, training and experience of the health care provider. I would first like to dispel the misconception that psychiatrists and psychologists are competing providers of services to patients with mental disorders. They emphatically are not comparable. Psychologists and other mental health providers, such as social workers and psychiatric nurses, are able to perform psychotherapy, but they do not possess the psychiatrists' qualifications of medical training and experience to medically assist patients. As you well know the Medicare population is a complex one. Often Medicare patients have more than one physical disorder and their multiple comorbidities may be further exacerbated by the interaction of the many medications they take. The medical differential diagnosis of the Medicare patient is a complex one requiring the expertise of physicians. Without regard to the matter of the extent to which the physical examination is or is not performed by an individual psychiatrist: "The role of the physical examination in psychiatry is no different than the role of the physical examination in other medical specialities." (Patten, 1988). "...The physical examination is important in the assessment of all psychiatric patients, but is nowhere more important than in the evaluation of patients with organic mental disorders. Organic disorders can present with a wide range of symptoms and signs and, as a result, they enter into the differential diagnosis of a large number of psychiatric disturbances (Patten 1988)". Where psychiatrists are not available, other physicians must provide the patient's mental illness differential diagnosis and treatment plan.

Psychologists are not capable of making this differential medical diagnosis. However, psychiatrists, like other physicians, have graduated from a medical school and have successfully completed a curriculum in, among other courses, Anatomy, Biochemistry, Microbiology, Pharmacology, Physiology, Pathology, Internal Medicine, Pediatrics, Surgery, Obstetrics and Gynecology, and Psychiatry. After graduation, the psychiatrist completes a year of medical, hospital-based clinical and practical training before a license to practice medicine is granted--a full five years of training is completed before psychiatrists begin a three year full-time residency in

psychiatry, specializing in the medical differential diagnosis and treatment of mental illness and its comorbidity factors, as well as psychotherapy and other treatment techniques. Psychiatrists thus complete a total of eight years of full-time medical education. Psychologists receive education in understanding human behavior through psychologically, not medically-oriented, techniques. Psychologists' one year of training before licensure is not medically-oriented. Psychiatry and psychology are not interchangeable disciplines. They are complementary disciplines which may at times use similar psychotherapeutic procedures.

Psychologists make a psychological diagnosis and treat patients with psychological techniques only. Interestingly, they allege that where medical treatment is needed they will in good conduct, practice and ethics request medical assistance. But even more interestingly they are not trained to determine that medical assistance is needed. As physician-specialists, psychiatrists treat patients with both biological and psychological methods. Researchers continue to discover the biochemical causes of severe mental illnesses such as schizophrenia, manic-depression, panic disorders and Alzheimer's Disease, and these disorders require medical management. Studies have shown that "major medical illnesses remain undiagnosed and patients' ailments are being labeled psychosomatic at an alarming rate. A careful screening of 2,090 psychiatric clinic patients (over a seven year period) showed that 43 percent of this population suffered from one or several physical illnesses...Almost half (46 percent) remain undiagnosed by the referring source..." (Koranyi, 1979). Findings in this same study suggested that many of these physical illnesses exacerbated the psychiatric state of patients and in 18 percent of the cases, patients' physical illness caused the psychiatric symptoms. Many physical illnesses present as psychiatric illnesses including: endocrine problems such as hypothyroidism; neurological disease such as myasthenia gravis; Alzheimer's Disease; multiple sclerosis; brain tumors; pancreatic carcinoma; and electrolyte and fluid imbalance. Evidence also suggests that certain medicines such as beta blockers for high blood pressure may cause severe depression, and the treatment is really a change in the medicine or dosage. Treating the symptoms of a disorder may thus be costly for patient care and may result in inadequate quality of care for patients. In no way do we suggest that an appropriate treatment plan will always involve psychopharmacological agents, rather an exclusively nonmedical psychotherapeutic approach may be appropriate after medical intervention and after a medical treatment plan has been developed.

The literature has clearly established the need for a comprehensive medical assessment of patients with mental disorders. Some physician-authors further suggest that because close to half of psychiatric patients have a mental disorder exacerbated by serious medical illness, and for between 9 and 18 percent of these patients the physical disorder was the direct cause of the psychiatric disorder, the following, among other components, must always be addressed: physical illness be included in every differential diagnosis of behavioral symptoms; a complete diagnostic medical assessment be performed at the time of the presentation and appropriate laboratory and physical examinations be conducted (Hoffman and Koran 1985).

Access to Care

We appreciate that much of the Congressional interest in expansion of psychologists' direct reimbursement under Medicare stems from concern about access to mental health services. We believe not only that the problem has been exaggerated, but also the argument obscures —as previously stated— the critical differences in training and competencies of psychologists and psychiatrists. Just being able to call someone Doctor does not make him/her a physician.

Although direct reimbursement of psychologists under private health insurance covering 65 percent of the population is widespread, underserved areas remain. It is unlikely that changes in reimbursement under Medicare, which affects 12 per cent of the population, will accomplish what private insurance has not and drive psychologists into the 1,476 counties with neither psychologists nor psychiatrists or the 277 counties with neither psychologists nor psychiatrists in the same or adjacent counties.

An independent analysis conducted for APA by LEWIN/ICF suggests that while access to mental health services may be a problem, expansion of psychologists' direct reimbursement is unlikely to do anything to significantly address the problem. The study defined psychologists as doctoral level individuals licensed for independent practice. Psychology is an exceedingly heterogenous profession, and the study assumed that this category of psychological professionals, while not trained as physicians, were trained as psychodiagnosticians and therapists. Using these assumptions, the study found that the majority of this type of psychologist practices in areas where psychiatrists practice. By examining the number of counties lacking only psychiatrists not all physicians, the access problem is exaggerated, since the proportion of the population in these areas is low and many individuals living in counties without psychiatrists have access to psychiatrists in counties adjacent to the ones in which they live. Fourteen percent of the population as a whole and 16.6 percent of the elderly population reside in the 65 percent of counties without psychiatrists. (There may be other physicians in these counties.) Many of the counties without psychiatrists have —without regard to primary care physicians— psychiatrists in immediately adjacent counties and some of these counties are, in fact, urban counties where access is much less of a problem. Only 1.3 percent of the total population and 1.8 percent of the population over 65 live in counties without psychiatrists in the county or an adjacent county. Although not all of the psychiatrists in adjacent counties would be accessible to patients, many would be. Simply stating that such counties without psychiatrists have no care gives clearly exaggerrates the problem. Of the 326 U.S. counties without psychiatrists in the county or an adjacent county, only 49 of these, with .03 percent of the U.S. population have psychologists. There are 79 psychologists in these counties. Even if one examines the counties with no psychiatrists, there are only 840 psychologists in these counties to possibly assist patients, and that assumes the patient needs the mental health care such pyschologists are trained to provide to them.

The above mentioned study showed that 95 percent of psychologists practice in counties with psychiatrists. Only one in five counties without psychiatrists have psychologists. Nine percent of the population resides in counties without both psychiatrists and psychologists and 10.9 percent of the population over age 65 resides in counties with neither psychiatrists nor psychologists. To extend direct billing to only 840 psychologists in counties without psychiatrists nationwide, H.R. 774, would extend direct billing to over 34,000 psychologists in counties with psychiatrists nationwide. In Pennsylvania, 53 of the 67 counties have psychiatrists providing access to close to 97 percent of the population. All fourteen counties without psychiatrists, have psychiatrists in an adjacent county. Seven of the fourteen counties have no psychiatrists or psychologists. In California, 43 of the 58 counties have psychiatrists to treat 98 percent of the elderly population. All counties have psychiatrists in the same or adjacent county. Eight counties have no psychologists or psychiatrists. We would be pleased to provide you with additional detailed county by county information for your own states.

Costs of Care

Expansion of reimbursement to other health providers does not reduce costs for a number of reasons. First, there is no substitution but rather costs accrue due to the additive nature of nonphysicians' care. Second, fees of nonphysician providers are not substantially lower. Third, misdiagnosis can also result in added costs. As the Ways and Means Committee moves to reform Part B of Medicare it is hoped that the additive nature of the costs of other health providers will be examined, before further expansion. To us, the Congressional Budget Office first year estimate of only 10 million dollars and 95 million dollars over five years fails to consider some of the cost factors we have mentioned.

Many independent analyses conducted for various agencies and private insurers have demonstrated that nonphysicians' charges often rise to be equivalent to those of physicians once insurance reimbursement is expanded. The claim of cost saving through reimbursing nonphysician providers is a spurious one. For instance, preliminary analysis of CHAMPUS data showed that the number of outpatient visits to psychiatrist/physicians between October 1984 and March 1986 were approximately seven visits per CHAMPUS beneficiary, as contrasted to the number of visits to extramedical counselors which were approximately 12 visits per beneficiary. Thus without regard to any dispute of cost per visit between physicians and nonphysicians the total costs were certainly greater where total nonphysician visits were considered.

Misdiagnosis of physical illness can result in added costs. With roughly 50 percent of patients with mental disorders, physical illness is an aggravating cause of mental illness and in 9 percent to 18 percent of the population of outpatient cases, physical illness may cause the symptoms of mental illness. These studies did not present separate data on the elderly—who most often have multiple comorbidities. Misdiagnosis causes added costs through: misallocation of resources; unnecessary treatment; and more costly medical treatment resulting from the original initiation of care.

In another public program, Medicaid, only 22 States reimburse psychologists as independent practitioners although their services are covered in many settings. As a cost containment measure, New York is considering eliminating direct reimbursement to psychologists.

Changes to H.R. 774

APA recommends that H.R. 774 be amended to ensure that the mental health treatment of a Medicare patient is medically necessary and appropriate. To achieve that objective we urge, as a condition precedent, that there be a medical differential diagnosis and a treatment plan by a physician, preferably a psychiatrist, before reimbursement to psychologists for mental health treatment.

Summary

Let me close by saying that quality medical care for patients and interdisciplinary management are at the heart of the training of a psychiatrist—part of the integral training that encompasses both the biological and psychological approaches to the understanding and treatment of mental disorders. We are concerned about the delivery of quality medical care to our patients. We suggest to the Committee that" freedom of choice" is an interesting, rhetorical phrase and that the Committee consider its boundaries and true meaning both as to the protection of patient quality of medical care and expenditure expansion. APA would suggest that the expanded expenditures be used to eradicate the arbitrary limit for treatment placed on mental illness and begin with the discriminatory patient burden of an effective 50 percent copayment on much of outpatient care as contrasted to the 20 percent copayment for other medical treatment. This Committee began the legislative journey toward nondiscrimination for the mentally ill under Medicare in 1987. Let's begin to end the mental illness stigma—at least for our fragile elderly and severly disabled— and have their disorders covered where they belong in the mainstream of medical and other health care.

We did not oppose Medicare reimbursement of psychologists' services in Community Mental Health Centers and Rural Health Clinics. Now we only ask that together we all work toward providing medically necessary and appropriate quality mental health care to our patients.

Dr. SABSHIN. May Dr. Hamilton make a brief statement?

Chairman STARK. Certainly.

Dr. HAMILTON. I am Dr. John Hamilton, deputy medical director of the APA. I am privileged to be here this afternoon.

I also had the privilege of serving the citizens of the country in the public sector as director of public hospitals over a period of 30 years and have subsequently been in the private practice of psychiatry in rural and urban areas in the country for a period of 5 consecutive years before I came to my position in the APA.

I want to emphasize and reinforce three particular points that Dr. Sabshin made.

One has to do with the importance of the medical diagnosis and the medical treatment plan, which is so essential to being a forerunner to anything occurring in the treatment arena, particularly with the patients covered by Medicare. Remember, those are the patients who are severely disabled and under 65 and those who are over 65. So we are talking about people who are patients with differences, frequently comorbidity and multi-morbid diagnostic situations.

It would seem to me to be very, very deficient and lacking in foresight to believe that we would be saving money or providing the quality kind of care that these patients must have and that they have been deprived of for such a long period of time if we deprive them of the possibility of a medical diagnosis and medical treatment plan before whatever treatment proceeded to occur for their benefit.

The fact of having a good comprehensive medical diagnosis and treatment plan, first, will frequently be money-saving because we will catch those disorders which can be treated effectively and reasonably with quick interventions many times and avoid the more expensive long haul for those things which can occur if there is no medical diagnosis or treatment plan.

In response to something I heard in the previous testimony about the acceptance of assignment, it should be stated that the rate of assignments among psychiatrists for Medicare is higher than many of the other 32 medical specialties.

The other thing I would like to speak about has to do with access and with costs.

Frequently, we say that something is going to be so very costly that it provokes an inhibition against it because we don't want to spend the money, we don't have the money to spend. One of the things the American Psychiatric Association has done and one of the things that I have been intimately involved with throughout my professional career has to do with the delivery of quality services to patients, that is, making sure that individual providers and facilities responsible for the provision of care live up to standards and criteria which reflect the highest order of performance that our patients and citizens require who happen to be sick and require medical intervention.

One of the things that has proven to be very important in the CHAMPUS program, since that was mentioned in the mental health arena, is the insistence that individual practitioners and institutions live up to a standard of quality in providing care or else

be denied access to the privilege of giving the care or denied reimbursement if they fail to live up to those standards.

Our association has been a forerunner of providing that kind of quality standard and criteria setting and enforcing it among our own members and institutions where our members work. I think that should be valuable information for the committee.

Chairman STARK. Thank you.

I am going to ask both of you gentlemen this question. It would be my assumption—and I think we heard testimony about it today—that probably two-thirds of Medicare beneficiaries see a doctor rather regularly. I imagine that number gets very high as they get older and may not be as high when they first enter the Medicare program. So it is almost, to me, then a matter of indifference. If I could identify those two-thirds of the people, whether they go to a psychologist or psychiatrist, because they are in fact seeing some physician who for one reason or another has not seen fit to refer them for either psychiatric or psychological counseling, and if there was some medical problem they missed it.

That may have been very much a problem in our overall fee-for-service and highly specialized medical delivery system, but nevertheless I have a hunch that that is the case. So a lot of this seems to be moot.

If I just said that anyone who would have had to have seen a doctor once a quarter for the previous four quarters, I will bet 50 percent of the previous Medicare beneficiaries could qualify. If the rules are being followed, they have all had some kind of a differential diagnosis. I have heard that you cannot have a lens implant or a bunion removed without a differential diagnosis.

It would be very nice, I suspect, if they could have a team of health care providers servicing them, but as a practical matter they do not. So it is hard for me to see any real danger lurking out from one side of the issue or the other.

On the other hand, it seems to me that we are dealing with professionals and unfortunately we are going to get into this soup with masters of social work folks and nurse practitioners. I am not suggesting this because I think it will save any money for the Medicare program, but I wonder if there is not a bit of a tempest in a teapot situation here, not as between whether a psychiatrist first sees the patient, or a psychologist, but we have a lot of M.D.'s out there seeing patients and I suspect a very small percentage of these patients get to either a psychiatrist or a psychologist.

We may be having difficulty doing more good than we are doing harm. In a perfect world—and we are so far from that, so fantastically far from giving that to our senior citizens unless they are rich and live in areas where it is readily available. We are dealing with 20 percent of the most well-to-do seniors in the country, and the other 80 percent would be lucky if they got to see a podiatrist. That is sad. I don't know the answer.

But it seems to me we are frustratingly close if we could get some cooperation between your profession and the psychologists.

Mr. Gradison.

Mr. GRADISON. In your testimony you indicated that psychologists are not capable of making the differential medical diagnosis, and I understand that. You also indicated that the psychiatrists

are capable of making the differential diagnosis, and I understand that, too.

My question is, on the average, if one were to look at all the patients receiving psychiatric care in the country, what proportion of them will have received the appropriate differential medical diagnosis by a psychiatrist? And what proportion will have received the appropriate differential medical diagnosis by a nonpsychiatrist physician?

Dr. SABSHIN. Your question is a complex one. It is like talking about what is the highest, largest lake when you bring all of these issues together.

There is no question that the larger proportion of patients are being seen by the nonpsychiatrist physician, certainly in the outpatient world. If you are asking me, of that group, what proportion are correct differential diagnoses, I don't know the answer.

Mr. GRADISON. That is not my question.

My question is, of those who end up seeing a psychiatrist, what proportion received the overview as to their physical condition from a psychiatrist and what proportion from a nonpsychiatrist physician?

The reason I ask is that in my limited exposure to this issue it appears that it would be very rare for a psychiatrist to examine a patient and render a judgment on the physical reason for his or her difficulties. The psychiatrist would look to the nonpsychiatrist medical doctor to do that in a typical case. I am not sure that is correct, but I would like to sort it out.

Dr. SABSHIN. In the practice of psychiatry 30 or 40 years ago, there was a tendency among some practitioners, especially the psychoanalysts, to say it is wrong to do a physical diagnosis, that it interferred with the patient-doctor relationship. That was a common perception, that they had difficulties with physical processes.

This is changing. Among the younger psychiatrists there is a much greater effort made to do the entire physical examination and make the full physical diagnosis. That is the current pattern and we are seeing a generational change in that regard. There are more and more.

There are still some psychiatrists who refer to other physicians to do the physical examination. I cannot give you a precise proportion, but I can tell you that the tendency is for a remedicalization of psychiatry, a reinvigoration of activity related to making that differential diagnosis.

Dr. HAMILTON. Indeed the standard of practice by which we hold psychiatrists accountable requires that they be responsible for the full medical differential diagnosis and the treatment planning for each patient who comes under their care.

Dr. SABSHIN. If they fail to, they can be sued for failing to make a diagnosis of a brain tumor or whatever. That is adding increasingly to the scope of psychiatric practice.

Mr. GRADISON. How would you respond to the question posed earlier by our chairman to the previous witnesses with regard to what one of the witnesses described as a consultative process, that is, where the psychologist would be required, before entering into extensive, long-term assistance to the patient, to ascertain by consul-

tation with the patient's physician whether there is any physical illness which might be a major explanation for the apparent emotional or mental disorders that the psychologist was trying to assist with?

You probably heard the question, if we could call it up we would. I wonder how you would answer the same question.

Dr. SABSHIN. Let me try.

I believe that the differential diagnosis should be made before treatment starts—that is a slightly different answer than what you heard before—and by whatever process that occurs. If in fact this legislation passes with the possibilities that after such a differential diagnosis there would be referral to a psychologist, social worker or psychiatric nurse, that would be fine.

The emphasis I am making is to look at the total picture, which in the Medicare population is predominantly that of comorbidity with the physical illness. It is hard to convey how often one sees that in treating patients with cancer who do not have a close relationship with their physician, how often they get depressed, or in the treatment of high blood pressure, patients who get high blood pressure medication, often have memory problems or they get confused.

I hope that there would be an effort both for the needs of a patient and also to try to develop an effective, cost-efficient mechanism in this country which we need so that such a diagnosis could be made before treatment is instituted. If such a diagnosis cannot be made until after all the Medicare benefits are used up, we need to find a better way.

We should try to find a way that such a compromise of getting an adequate differential diagnosis can be made. I don't think I know all the answers to that, but out of the experience I have, I know it is necessary to try to understand what is wrong before treatment is instituted.

Mr. PICKLE. Would the gentleman yield?

Mr. GRADISON. Yes.

Mr. PICKLE. We might be getting closer to a compromise. Whether it is the chairman's approach to coordinating through consultants or through the chairman's program, there ought to be a way to get a better diagnosis.

I think you said if you did refer to a psychologist, that would not improve quality care. Are you saying that?

Dr. SABSHIN. Let me give you my personal answer.

I think there are times when a psychiatrist should and does refer to a psychologist. Dr. Cummings indicated this had happened to him frequently. It is not that psychiatrists are hiding their patients and won't refer them. There are many examples of collaborative relationships between professions.

We argue now what needs to be ascertained before a psychological treatment starts.

Mr. PICKLE. If we take that for the assumption, that means the patients will go to the M.D. first?

Dr. SABSHIN. Yes, sir.

Mr. PICKLE. That is what is happening now. In many cases the psychologist is not properly brought into the circle. Now, there ought to be some way. There are times when some patients ought

to go to a psychologist first, in my opinion. Normally it would be through the physician.

I have the feeling that the psychologists are not brought into this thing. If it is not quality care, then we ought to have a different system.

Are you familiar with the CHAMPUS system?

Dr. SABSHIN. Dr. Hamilton is more than I am, sir, so I will let him pick that up.

Mr. PICKLE. Do you want to comment?

Dr. HAMILTON. I don't think anything we have said should be interpreted to mean that we believe that psychologists do not deliver quality care. That is not true. Psychologists certainly can deliver quality treatment services in the area that they are trained to do.

The point we are making is that we should not try to institute psychological behavioral treatment as an original entree to the patient's pain and disorder before a differential diagnosis.

Mr. PICKLE. I understand.

Dr. SABSHIN. It is not like they are two different words.

I think, to make the medical diagnosis is a somewhat broader process. If the medical diagnosis includes the psychological also, then X is larger than Y. The sequence flows from that, rather than saying each of the sequences is equivalent.

Chairman STARK. Mr. Levin.

Mr. LEVIN. There is a reference from Dr. Welch of 75 to 85 percent of all mental health services not coming from a specialist but coming from all physicians. You said that a majority of these services come from a general practitioner.

Dr. SABSHIN. I meant nonpsychiatrist, yes.

Mr. LEVIN. If the choice is between a licensed psychologist and a general practitioner to receive mental health services from, in general where is it better to be seen?

Dr. SABSHIN. I would love to be in a position to make that decision.

Mr. LEVIN. But in terms of the patient, where is it better for her or him to go?

Dr. SABSHIN. My answer, to be very serious, is that it is better at times to go to a psychologist and it is better at times to go to a nonpsychologist.

Mr. LEVIN. This is for mental health service.

Dr. SABSHIN. Let me explain.

If the patient has a depression which I believe could be helped by psychotherapy, I would certainly refer——

Mr. LEVIN. Forget about referral. I don't want to get into that.

For the majority of seniors receiving mental health services today, they are receiving them from general practitioners rather than a psychiatrist or psychologist.

Dr. SABSHIN. Right.

Mr. LEVIN. Is it better or not for that Medicare patient receiving mental health services that it comes from a psychologist rather than a GP, from a mental health professional rather than from a nonmental health practitioner? Isn't it better on balance?

Dr. SABSHIN. Yes.

I am hopeful that it still might be possible to insert into the report some of the caveats to what I just said. You asked me, talk-

ing about the overall population involved and is it better looking at it en masse, and I agree with you that it is better that way.

Mr. LEVIN. I was hopeful that you would answer that way, and it seems to me that it points you in a certain direction. You talk about quality; the Medicare patient is receiving mental health services from someone who is not a mental health professional in more than half of the cases. The psychiatrists in this country should be working to find a system where the people with a mental health problem receive services from a mental health professional. This is what I think everybody on this panel of members is aiming at. I think we made some progress today.

You, as psychiatrists, should be very disturbed, it seems to me, that mental health services are provided in the main today by nonmental health professionals.

Dr. SABSHIN. Sir, I devoted a large part of my career to improve those services performed by nonpsychiatrists. I know how far we have to go.

Since you did not give me the choice, and I understand why you did not, I would prefer that more of that work be done by psychiatrists. Part of the reason it has not been done has been the access problem that affected care by psychiatrists, the problems of low reimbursement, stigma that has limited that.

I am hopeful there can be a change on all fronts in order to deal with the full totality and poignancy of all the problems of the older people we are talking about.

But I have answered your question the way you asked it.

Mr. LEVIN. As you know, I am with you on that, and this subcommittee is.

I had the privilege of sponsoring the increase in the reimbursement. I think I must say to you, based on the ambience, the whole atmosphere of this hearing, that one of the reasons we have so much trouble elevating the reimbursement for the mental health services is the in-fighting within the profession.

You responded to Mr. Gradison's question but then I think you lapsed into an inflexibility. You talk about initial entree. I don't think you are searching vigorously enough to find a way that more and more seniors in this country are seen by mental health professionals for mental health problems, instead of nonmental health professionals, because of an overfixation of one versus the other, so the end result is that it is neither in most cases.

You are resolving this by working with this subcommittee, and I think you want to find a way to resolve the diagnosis problem.

The chairman is not saying that before a person can see a psychologist, there must be a fresh diagnosis; what is suggested is that we take the reality that most seniors are seeing physicians all the time and find a way for a mental health professional to see those seniors, with reference by a nonphysician to a physician within an adequate period of time. We need to resolve that.

I will just say to you, until the professions work together to resolve it, you are going to find antipathy continuing within these halls to raising what is still much too inadequate a basis for reimbursement.

Dr. SABSHIN. Sir, I know what you contributed to the Medicare situation and I am grateful to you. I take your remarks about the medical rivalry seriously.

Also, the stigma or stigmata against the mentally ill preceded the turf problems. I think we need to see how the interaction of forces affects the support we are talking about. It may not just be the turf battles.

Mr. LEVIN. I accept that. The collaboration among people who come from the same place would help to reduce the stigma. It is not its cause, but it surely adds to it.

It is about time that all of us who are concerned with the adequate provision of mental health services quit losing the forest for a few trees. We must find a way out of the diagnostic issue. There is a desire here to do so. I think you sensed it from each and every one of us. I hope it is equally forthcoming from you and the psychologists and the other mental health professions.

Thank you.

Chairman STARK. Mrs. Johnson.

Mrs. JOHNSON. Thank you, Mr. Chairman.

I welcome the members of our panel.

On this issue of the differential diagnosis preferably preceding referral to a psychologist, when you look at the national mental health care system, the care that not only physicians and psychiatrists, but psychologists, psychiatric social workers and social workers provide, there is a very small segment of those patients receiving a differential diagnosis before they receive mental health care.

I don't see any overwhelming data arising to demonstrate that that is a great mistake. In other words, if you look at all the mental health care being given out across the board to deal with emotional problems, in a very small percentage of those cases is the referral from a physician, much less a psychiatrist. Yet there is no evidence that physical causes are being broadly neglected.

How do you respond to that?

Dr. HAMILTON. I think that the appropriate way to look at that is to look at the total population and what happens in age differentiation.

The population between the ages of 20 and 55 form the bulk of those people who get the services which do not have a preceding differential diagnosis, this is a population where there is very little physical morbidity in comparison with the percentage of physical morbidity which exists in the population 65 and older.

So the population of which you speak does not include disabled patients who have Medicare and are under 65, and it does not generally include the citizens 65 and older because in those populations there is such a dense degree of physical comorbidity and multiple comorbidity that it overshadows the age group 20 to 55.

Dr. SABSHIN. Mrs. Johnson, I would be delighted to see a more precise diagnosis made even among younger people. One of my long-term hopes is that that should occur.

I believe there should be an adequate appraisal for all people who get mental health services in order to judge what is done. One sees this problem, too, in younger people. Dr. Hamilton's point about the increased prevalence with the problems that demand such diagnosis is the answer to your question.

Mrs. JOHNSON. One could argue which should happen first. It appears there is a collaborative relationship, and physical problems get recognized and bubble over to the physician's side, as physicians are not always good at analyzing psychological problems.

I am not sure we are making any more mistakes from the one side to the other. I don't know that there is any research to support what you say about the difference between the 20 to 55 age group or the 55 and over.

Dr. HAMILTON. Yes, there is, and we would be glad to send that over to you.

Mrs. JOHNSON. I would like to see that.

[The information follows:]

The following tables demonstrate the increased incidence of chronic illness in the elderly population; common problems coexisting in the elderly population; and disorders likely to present nonspecifically in old age.

TABLE 57. NUMBER OF SELECTED REPORTED CHRONIC CONDITIONS PER 1,000 PERSONS, BY AGE: UNITED STATES, 1986

(DATA ARE BASED ON HOUSEHOLD INTERVIEWS OF THE CIVILIAN NONINSTITUTIONALIZED POPULATION. THE SURVEY DESIGN, GENERAL QUALIFICATIONS, AND INFORMATION ON THE RELIABILITY OF THE ESTIMATES ARE GIVEN IN APPENDIX I. DEFINITIONS OF TERMS ARE GIVEN IN APPENDIX II)

TYPE OF CHRONIC CONDITION	ALL AGES	UNDER 45 YEARS			45–64 YEARS	65 YEARS AND OVER		
		TOTAL	UNDER 18 YEARS	18–44 YEARS		TOTAL	65–74 YEARS	75 YEARS AND OVER
SELECTED SKIN AND MUSCULOSKELETAL CONDITIONS	NUMBER OF CHRONIC CONDITIONS PER 1,000 PERSONS							
ARTHRITIS	130.8	30.2	*2.0	47.9	284.6	480.4	443.3	540.1
GOUT, INCLUDING GOUTY ARTHRITIS	9.4	*1.5	—	*2.5	24.0	32.8	28.5	39.6
INTERVERTEBRAL DISC DISORDERS	17.6	13.2	—	21.4	39.5	13.1	*14.5	*16.2
BONE SPUR OR TENDINITIS, UNSPECIFIED	7.1	3.9	—	6.3	16.6	11.0	*12.1	*9.3
DISORDERS OF BONE OR CARTILAGE	5.9	3.3	*0.7	4.9	6.9	19.9	19.5	*20.5
TROUBLE WITH BUNIONS	12.3	5.5	*1.1	8.3	21.4	38.2	32.9	46.7
BURSITIS, UNCLASSIFIED	17.4	8.6	*0.9	13.5	36.7	37.9	43.0	29.6
SEBACEOUS SKIN CYST	6.4	5.1	*0.8	7.7	12.0	*9.6	*6.6	*7.2
TROUBLE WITH ACNE	18.2	25.0	21.4	27.2	*4.2	*0.9	*1.5	—
PSORIASIS	9.9	7.0	*2.2	10.0	13.8	20.7	17.7	*25.7
DERMATITIS	40.4	43.4	42.0	44.3	35.4	30.4	33.6	*25.2
TROUBLE WITH DRY (ITCHING) SKIN, UNCLASSIFIED	19.5	17.0	9.1	21.9	21.0	31.8	27.7	38.4
TROUBLE WITH INGROWN NAILS	22.8	16.0	9.7	20.0	32.9	48.6	39.6	57.8
TROUBLE WITH CORNS AND CALLUSES	20.4	12.6	*1.6	19.4	34.0	45.3	39.7	54.4
IMPAIRMENTS								
VISUAL IMPAIRMENT	35.3	22.3	12.2	28.7	46.3	99.0	69.3	136.3
COLOR BLINDNESS	12.5	11.5	5.6	15.2	16.3	1.9	18.5	*3.9
CATARACTS	21.3	*1.2	*0.6	*1.5	21.1	141.4	84.3	233.2
GLAUCOMA	7.2	*0.8	*0.6	*0.9	10.3	40.4	29.1	58.5
HEARING IMPAIRMENT	87.7	39.6	20.1	51.8	136.2	9.6	246.2	378.4
TINNITUS	26.7	10.8	*3.6	15.3	49.2	9.2	83.2	88.3
SPEECH IMPAIRMENT	11.8	12.7	18.2	9.3	8.3	2.2	*9.6	*10.4
ABSENCE OF EXTREMITIES (EXCLUDES TIPS OF FINGERS OR TOES ONLY)	7.1	3.2	*0.3	5.0	13.1	20.7	22.8	*17.3
PARALYSIS OF EXTREMITIES, COMPLETE OR PARTIAL	6.2	3.5	*1.3	4.9	10.0	19.9	*11.6	*22.9
DEFORMITY OR ORTHOPEDIC IMPAIRMENT	115.9	93.8	32.5	132.2	161.6	172.7	158.4	195.7
BACK	68.9	57.1	16.7	82.4	92.0	101.5	93.0	119.1
UPPER EXTREMITIES	13.1	10.0	*2.2	14.8	23.2	15.4	*13.8	*18.1
LOWER EXTREMITIES	49.4	37.3	16.0	50.7	69.8	88.4	76.5	107.4
SELECTED DIGESTIVE CONDITIONS								
ULCER	19.0	13.3	*0.6	21.3	28.2	37.9	42.9	30.0
HERNIA OF ABDOMINAL CAVITY	19.4	7.6	*2.7	9.5	36.9	61.2	46.5	84.8
GASTRITIS OR DUODENITIS	12.2	8.3	*2.8	11.8	20.9	21.4	21.4	*21.4
FREQUENT INDIGESTION	22.5	17.1	*3.9	23.4	31.3	40.3	43.3	35.6
ENTERITIS OR COLITIS	10.1	7.4	*2.8	10.3	11.1	24.4	*11.2	46.2
SPASTIC COLON	6.9	5.9	*0.8	9.2	10.7	*6.8	*7.8	*5.0
DIVERTICULA OF INTESTINES	8.1	*1.1	—	*1.7	12.8	42.2	41.9	42.7
FREQUENT CONSTIPATION	19.2	10.9	5.6	14.3	22.1	63.7	51.2	83.9

SEE NOTES AT END OF TABLE.

TABLE 57. NUMBER OF SELECTED REPORTED CHRONIC CONDITIONS PER 1,000 PERSONS, BY AGE: UNITED STATES, 1986—CON.

(DATA ARE BASED ON HOUSEHOLD INTERVIEWS OF THE CIVILIAN NONINSTITUTIONALIZED POPULATION. THE SURVEY DESIGN, GENERAL QUALIFICATIONS, AND INFORMATION ON THE RELIABILITY OF THE ESTIMATES ARE GIVEN IN APPENDIX I. DEFINITIONS OF TERMS ARE GIVEN IN APPENDIX II)

TYPE OF CHRONIC CONDITION	ALL AGES	UNDER 45 YEARS				45 YEARS AND OVER		
		TOTAL	UNDER 18 YEARS	18–44 YEARS	45–64 YEARS	TOTAL	65–74 YEARS	75 YEARS AND OVER
	NUMBER OF CHRONIC CONDITIONS PER 1,000 PERSONS							
SELECTED CONDITIONS OF THE GENITOURINARY, NERVOUS, ENDOCRINE, METABOLIC, AND BLOOD AND BLOOD-FORMING SYSTEMS								
GOITER OR OTHER DISORDERS OF THE THYROID	13.6	7.3	*2.6	10.3	29.1	25.8	23.8	29.1
DIABETES	27.9	6.3	*2.4	8.7	63.7	98.3	91.9	108.5
ANEMIAS	13.5	12.2	7.3	15.2	12.9	22.3	24.4	*18.9
EPILEPSY	6.6	6.9	6.2	7.3	6.3	*4.0	*1.4	*8.3
MIGRAINE HEADACHE	36.0	36.0	14.6	49.4	49.5	20.8	21.3	*20.1
NEURALGIA OR NEURITIS, UNSPECIFIED	2.6	*0.6	—	*1.0	*4.7	*9.8	*9.7	*10.0
KIDNEY TROUBLE	16.8	12.3	4.6	17.3	23.3	32.8	28.8	39.3
BLADDER DISORDERS	16.0	10.5	*2.4	15.5	22.2	38.5	29.5	53.0
DISEASES OF PROSTATE	5.9	*0.9	—	*1.4	12.5	25.1	26.7	*22.6
DISEASE OF FEMALE GENITAL ORGANS	18.2	19.7	*2.8	30.2	20.8	*5.3	*8.5	—
SELECTED CIRCULATORY CONDITIONS								
RHEUMATIC FEVER WITH OR WITHOUT HEART DISEASE	7.0	4.3	*0.6	6.8	13.4	12.7	*16.0	*7.6
HEART DISEASE	78.1	32.5	21.7	39.3	123.2	276.6	250.0	319.4
ISCHEMIC HEART DISEASE	29.2	3.5	—	5.7	59.1	133.7	120.9	156.6
HEART RHYTHM DISORDERS	30.1	21.9	16.5	25.3	36.2	69.3	74.7	60.7
TACHYCARDIA OR RAPID HEART	8.1	3.9	*1.3	5.5	11.7	28.0	30.9	*23.2
HEART MURMURS	16.5	16.8	14.5	18.3	13.6	19.0	18.7	*19.5
OTHER AND UNSPECIFIED HEART RHYTHM DISORDERS	5.5	*1.2	*0.7	*1.5	11.0	22.6	25.1	*17.9
OTHER SELECTED DISEASES OF HEART, EXCLUDING HYPERTENSION	18.8	7.1	5.2	8.1	27.9	73.5	54.6	104.3
HIGH BLOOD PRESSURE (HYPERTENSION)	122.6	42.1	*1.9	67.2	250.6	394.6	385.2	409.2
CEREBROVASCULAR DISEASE	11.9	*1.1	*0.8	*1.3	18.1	65.9	46.7	96.7
HARDENING OF THE ARTERIES	11.2	*0.6	—	*0.7	21.7	58.5	38.0	91.7
VARICOSE VEINS OF LOWER EXTREMITIES	29.0	13.9	—	22.6	56.3	74.6	76.2	71.9
HEMORRHOIDS	41.9	29.1	*0.9	46.7	73.2	67.8	70.2	64.1
SELECTED RESPIRATORY CONDITIONS								
CHRONIC BRONCHITIS	48.1	46.8	63.2	36.5	45.8	60.0	62.9	55.6
ASTHMA	41.0	42.0	51.1	36.6	36.3	42.6	46.4	38.3
HAY FEVER OR ALLERGIC RHINITIS WITHOUT ASTHMA	91.8	94.3	64.3	113.1	95.8	70.6	72.6	67.2
CHRONIC SINUSITIS	149.5	130.2	65.8	170.6	187.0	169.6	168.6	170.7
DEVIATED NASAL SEPTUM	5.5	4.3	*1.6	6.0	7.9	*8.5	*13.8	—
CHRONIC DISEASE OF TONSILS OR ADENOIDS	13.3	17.9	29.7	10.6	*2.3	*3.6	*4.2	*2.0
EMPHYSEMA	8.5	*0.5	—	*0.7	18.6	40.0	44.5	32.7

NOTES: THE STANDARD ERRORS AND RELATIVE STANDARD ERRORS (RSE'S) CAN BE COMPUTED BY USING PARAMETER SET V OF TABLE I. THE FREQUENCIES OF TABLE 62 AND THE FORMULA PRESENTED IN RULE 2 OF APPENDIX I. ESTIMATES FOR WHICH THE NUMERATOR HAS AN RSE OF MORE THAN 30 PERCENT ARE INDICATED WITH AN ASTERISK.

Table A-24.—Most Common Problems Coexisting in Elderly Individuals

1.	Congestive heart failure
2.	Depression
3.	Dementia syndrome
4.	Chronic renal failure
5.	Angina pectoris
6.	Degenerative joint disease
7.	Gait disturbance
8.	Urinary dysfunction
9.	Constipation
10.	Vascular insufficiency in the legs
11.	Diabetes mellitus
12.	Chronic pain
13.	Sleep disturbance
14.	Multiple drug regimens
15.	Anemia

SOURCE: Besdine, et al., 1982 (6).

Table A-25.—Disorders Likely to Present Non-Specifically in Old Age

1.	Depression
2.	Drug intoxication
3.	Myxedema
4.	Alcoholism
5.	Myocardial infarction
6.	Pulmonary embolism
7.	Pneumonia
8.	Cancer
9.	Surgical abdomen
10.	Thyrotoxicosis, masked or apathetic

SOURCE: Besdine, Levkoff, Wetle, 1983 (7).

Source: Technology and Aging in America, (Washingtc U.S. Congress, Office of Technology Assessment, OTA-264, June 1985)

Mrs. JOHNSON. It has been claimed by preceding panelists that psychiatrists are not gravitating toward geriatric care and in fact psychiatrists are in many instances reluctant to treat geriatric patients. I am keenly aware of the increasing number of physicians who are choosing geriatrics as a specialty.

But excluding those, just as a person in the real world, that statement rings true with me that there is so much demand for care that psychiatrists do tend to treat the younger patients, the families, the middle-aged parent in distress. There is some genuine concern as to what portion of senior problems are treatable through the tools of analysis, as opposed to perhaps a different level of counseling and direction and mental health work.

How would you counter that comment, that psychiatrists are not flocking to treat seniors? Second, what percentage of the senior mental health problem really requires an analytical approach?

Dr. SABSHIN. When you say "analytic approach"——

Mrs. JOHNSON. I meant analysis.

A nonprofessional thinks about the differences of psychiatry and psychology as perhaps a different approach, and one looks at structural issues.

Dr. SABSHIN. I would appreciate an opportunity to sit down and talk with you about that. You seem to be equating psychoanalysis with psychiatry and a behavioral and structural approach to psychology. I think our colleagues might have some differences. There is more involved, with the psychologist in psychoanalysis. Psychiatry has moved into a world that is much more using limited psychotherapy with drug treatment. It is totally another world. That is what I was talking about.

I would enjoy presenting some figures to you about that.

[The information follows:]

The attached figure demonstrates that during the course of 1 week psychiatrists see over half of their patients for treatments involving a medical intervention, including those psychotherapy visits that involve medication supervision. These data are based on a 1982 survey and data from the more recent survey are likely to be available at the end of the year.

Figure 33. Percent of Patients Seen Per Week in All Employment Settings by Modality of Treatment: Active Respondents.

Total Mean Number of Patients Seen Per Week = 36.5

Source: The Nation's Psychiatrists, edited by Lorrin M. Koran, M.D., American Psychiatric Association, 1987.

Dr. HAMILTON. I think there has been an increasing interest among psychiatrists in the area of geriatrics. Indeed several of the pioneers in the whole area of paying attention originated with psychiatry. Dr. Busse at Duke University wrote about that several years ago. He predicted the situation which we have come to now with his innovative program in those years, which still goes on.

There are several other centers around the country now which are emphasizing the geriatric patient in terms of the problems they get into.

As Dr. Sabshin said earlier, the APA has recognized this by putting in areas which particularly refer to this. We are studying a subspeciality area and geriatric psychiatry is one we are considering in our organizational structure. We have a Council on Aging and a component which deals specifically with the problems of the aging population.

More and more psychiatrists are becoming more and more interested in the geriatric area because we know there is a special emphasis to deal with it.

Mrs. JOHNSON. Thank you for your comments. I do want to second the comments of my colleague from Michigan, Congressman Levin.

I think we need to be concerned that so much of our mental health care for seniors is coming from primary care physicians and that we ought to be seeing that as a sign that there isn't the ability to collaborate as strongly within our health care providers as there ought to be. So I welcome you working with us to find language that will help to move this issue forward.

Dr. HAMILTON. I think something may have been misunderstood. In speaking about patients who are under the care of a physician currently or who have recently seen a physician who has made this differential diagnosis, we certainly would not insist or wish that that person had that process repeated.

I just wanted that to be clear.

Mrs. JOHNSON. OK, thank you.

Chairman STARK. Mr. Moody.

Mr. MOODY. Just briefly, most of the questions I wanted to ask have been asked and I think much of the rationale boils down to access questions and I think that Congressman Levin's points are well-taken. While listening here I was glancing over an article in the Psychiatric Times by James T. Menninger, M.D., in which he says, "Psychiatric problems in nursing homes patients are often missed or inappropriately diagnosed and treated, and most psychiatrists have never set foot inside a nursing home."

He goes on to talk about how really inadequate psychiatric, as opposed to psychological services are for the current nursing home population and showing signs of not getting much better under current regimes.

It stresses the access problem that I think this bill attempts to get at. I don't think this bill is intended to alter turf division issues very much. I don't think that is the rationale. The bill is an access and service and quality of service issue since so many people are getting less than adequate psychiatric services under the current system.

Any comments?

Dr. HAMILTON. I would like to make one comment about the nursing home situation because I think that that is an appalling situation. And if you will recall for many, many years it was very difficult, if not impossible, to get psychiatric patients, per se, that is patients with known diagnosable psychiatric illnesses, into nursing homes at all because they were just excluded from nursing homes.

I think that that began a process of psychiatrists not being generally available for nursing homes because they were attending the elderly geriatric patients in other settings and I just wanted that to be clear.

Mr. MOODY. Whatever the genesis, it is an appalling problem, that they have such little access to psychiatric support.

Dr. SABSHIN. It could get worse. There is a new generation of elderly homeless because they are excluded from nursing home treatment.

Mr. MOODY. Right. We could think of this bill as helping us get ready for a tidal wave of problems that are coming at us. If current modalities and current systems don't address it very well now, you can imagine what will be the case in, let's say, 10 years from now. So maybe it is a time to rethink a fresh issue that we have been raising with this bill. Thank you for your excellent testimony.

Dr. SABSHIN. We are trying to do that in terms of both the bath tub and the baby.

Chairman STARK. Thank you both, gentlemen. We appreciate your testimony here today.

Our next panel will consist of Dr. Peter Rabins, associate professor of psychiatry at Johns Hopkins; Dr. Mark Beers, assistant professor of medicine at UCLA; Dr. Nathan Billig, professor of psychiatry at Georgetown; and Dr. Michael Smyer, professor of human development at the Pennsylvania State University.

Welcome to the committee, gentlemen. If you would like to, your prepared testimony will appear in the record in its entirety. If you would like to expand or elaborate on it in any manner that you are comfortable, please proceed.

Dr. Rabins.

STATEMENT OF PETER V. RABINS, M.D., ASSOCIATE PROFESSOR OF PSYCHIATRY, JOHNS HOPKINS UNIVERSITY SCHOOL OF MEDICINE, BALTIMORE, MARYLAND

Dr. RABINS. Thank you, Mr. Chairman. I am Peter Rabins, a psychiatrist. I have a clinical practice at Johns Hopkins, as well as a research practice there and among other things I have also coauthored a book called the 36-hour day which was directed toward helping families and professionals cope with the devastation of Alzheimer's disease.

What I would like to do is just sum up the five major points that I have tried to make in my testimony and just to clarify that I have been asked to particularly focus on issues in the nursing home, and that these are a little bit different than serving mental health care needs of the elderly in general.

First, I think it is important to realize that people in nursing homes have both "medical" and "psychiatric" symptoms. That is that almost everybody in a nursing home has a medical illness, but

it surprises most people to find that 50 to 70 percent of people in nursing homes also have psychiatric disorders as well. And in fact I think this distinction between medical and psychiatric in the nursing home often falls apart.

For example, individuals who have a stroke that appears in a certain part of the brain are at a 60 percent risk of developing a serious major depression. Now, do we call the depression psychological and the stroke medical? They get tied up and I think that make a mistake in trying to separate things in that way.

My second point relates to the first: that is that brain disease is very common in nursing home residents. I think every survey that has been done suggests that about 70 percent of people who reside in the nursing home suffer from dementia or some other form of organic brain disease. That is in contrast to the community where only about 5 percent of older people have a serious organic mental illness.

So when we are talking about people in the nursing home, they are different than older individuals in the community. I would just like to highlight one study done in New York State where they examined the records of 1,000 residents in nursing homes; of these individuals with dementia they found that 64 percent, two-thirds, had a moderate or severe behavior problem.

This is very important. That is the reality of the nursing home. That is often what got them there, not just the fact that they had Alzheimer's disease, but they also have a behavior problem. And although, as I will mention in a minute, I think medication treatment is sometimes necessary, I do think it crucial that we learn more about nonmedication treatments in nursing homes. I, frankly, think we know almost nothing about that, although I did want to mention that the NIMH has a book coming out next month, called "Alzheimer's Disease and Families Under Stress," that addresses some of this.

The third point is that we are quite ignorant about the use of medicine in nursing homes. Some of the other speakers are going to talk about the problems of drugs. We know that these medicines have serious side effects, that some of these complications are more disabling than the underlying problem and that very often the people prescribing these medicines and giving them know almost nothing about them. And, in fact, if you look at the charts, you can't find why the doctor is prescribing them or why the nurse is giving that medicine.

I think that is terrible. But in fact we really don't know whether these drugs work or not. That is a sorry state. My clinical experience suggests that there is a great deal of improper prescription of drugs. On the one hand people give too much medicine and ironically some of the people who need it aren't getting enough.

This is particularly true of antidepressant medicines, so that while we often talk in disparaging terms about the use of medication in nursing homes, I think what we should be saying is that it is a skill, an art, as well as a science. And we should demand that the people who are prescribing these drugs be properly trained. And I think that this has to be an issue that we look at quite carefully.

The fourth point that I want to make about people who live in nursing homes is that they are not a homogenous group. One can cut the pie in many different ways. I think one helpful way to realize that there are some people who stay in nursing homes a short period of time; in fact, although they only make up 9 percent of the admissions to nursing homes, they are 61 percent of the discharges. The turnover is so rapid in this group and they stay on an average less than 2 months. Most of these people are in the nursing home for either rehabilitation purposes, they have had a stroke or a hip fracture, stay a short period of time and then go back to the community or they have a very serious medical illness and they die within 2 months.

The other group of people, the long-stayers, stay on average of 2½ years. These individuals usually spend the last 2½ years of their life in the nursing home. And the best predictor of who these long-stayers are, is Alzheimer's disease or other organic brain disease.

I think this is important or several reasons. Number 1, it tells us that if we really want to decrease the number of people ending up in nursing homes, the only way to do that really is to find a cure and a prevention for Alzheimer's disease. I think that is key, although that is not directly related to this.

Second, it is crucial that we focus research on this group of people in the nursing home who are there a long time, and try to find out what kind of care do they need. What are the problems and what is the proper treatment.

We don't know that and I think there is almost nothing going on, and I think we should push the National Institute on Aging and the National Institutes on Mental Health to focus on those practical issues. How can we better care for the people already in homes?

Last, I think it is important to realize that nursing homes have undergone a dramatic transformation in the last 20 years. We don't speak about retirement homes anymore. There is a good reason. People don't retire to nursing homes. In fact, what I think will happen in the next decade is that nursing homes will become acute hospitals themselves.

This is already underway. They are really medical psychiatric hospitals. People who are leaving the general hospital much sicker than they used to, people who are already in nursing homes and become ill, for example, development of pneumonia are increasingly being treated in the home.

Again, we need to make sure that the people in nursing homes providing care do so in an appropriate manner. In sum, I would like to say that there are good homes and bad homes and I think that the best measure of our becoming able to improve nursing home treatment for elderly Americans will be when families can pridefully say that they have put their elderly loved one in a home and that that is the appropriate place for them, rather than the guilt that we seem to heap on people who have to put their family member in a home.

Thank you, Mr. Chairman.

[The statement of Dr. Rabins follows:]

THE "MEDICAL/PSYCHIATRIC" INTERFACE IN THE NURSING HOME

Testimony of Peter V. Rabins, M.D., MPH
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Mr. Chairman, ladies and gentlemen, thank you for inviting me to address the Committee on common medical/psychiatric issues which occur in nursing home care. In the time I will make 5 major points:

1. Nursing home residents commonly have both "medical" and "psychiatric" symptoms. I put these words in quotation marks because in many ways this distinction is an artificial one. We know that many of the psychiatric and behavioral symptoms present in nursing home residents arise from underlying physical disease and that certain psychiatric conditions, for example depression, can have major effects on physical functioning. It is particularly important that professionals working in nursing homes appreciate this common coexistence of physical and behavioral comorbidity. Nursing home practitioners, be they physicians, psychologists, nurses, social workers or activity therapists, must be knowledgeable about what have been traditionally termed medical and psychiatric conditions and be skilled in caring for persons who have symptoms in both realms.

2. A second point related to the first is that brain disease is very common in nursing home residents. Many surveys have demonstrated that between 50 and 70% of nursing home residents suffer from some form of dementia or what is sometimes referred to as organic brain syndrome (Rovner, American Journal of Psychiatry 143:1446-49, 1986). This is a change from the "retirement home" of 20 or 30 years ago to which healthy elderly "retired.".

Surveys done both within nursing homes and in persons residing at home with their families demonstrate that 1/2 to 2/3 of persons with dementia have behavioral symptoms and that these are often the main source of distress for families and institutional carers. In one notable study reported in 1984 by Zimmer in the American Journal of Public Health, the records of more than 1,000 residents of New York state nursing homes were surveyed. The authors found that 64.2% of the patients had a moderate or serious behavioral problem. The most common serious problems were being verbally disturbing to others (12.6%), being physically resistive to care (11.4%) and being physically aggressive towards others (8.3%). There is little scientific data telling us how best to treat these behavioral disorders. I believe we must learn much more about non-drug therapies and that improved nursing home environments will be one important strategy. Some of these non-drug treatments are being addressed in an NIMH publication being released next month entitled "Families Under Stress: Future Directions in Alzheimer's Disease Research."

3. We know little about the proper use of medications in nursing homes (Avorn, New England Journal of Medicine 320:227-32, 1989). Some of the other speakers today are addressing how commonly psychotropic drugs are prescribed in nursing home. Their research demonstrates that psychotropic medications have untoward results and that the reasons they are being prescribed are frequently not documented. However, this does not necessarily mean the medication use was improper.

My own clinical experience suggests that there is some improper prescription of drugs. Some patients are receiving psychotropic drugs when there is no clear indication for them while others are being treated with inadequate amounts. My experience also suggests that a significant number of nursing home residents do require treatment with psychotropic because of behavioral disorder. I find it shocking that very few studies have been done to determine whether these drugs do help and that no studies have been done which compare medication treatment to non-drug therapies.

While the prescribing of psychotropic drugs is often spoken of in disparaging terms I believe the opposite is true. The use of medication is both an art and a science. Practitioners who prescribe psychotropic drugs should be skilled in their use and should have a clear appreciation of the drawbacks of drugs as well as their potential benefits. It is imperative that we study why

these drugs are being prescribed, whether appropriate adjustments are being made and whether attempts to diminish or discontinue them are made at appropriate intervals. Only in this way will we be able to determine whether these drugs are ever helpful and, if so, when. It is equally important for us to know when psychotropics are not helpful; they have serious side effects and should not be used when they cannot help.

The vast majority of drugs used in medicine today have what are considered "mental" side effects. Almost every drug used to treat hypertension and most drugs used to treat heart disease and respiratory disease can effect memory and/or mood. For example, one of the most widely prescribed drugs in the past 5 years, cimetidine, which is used to treat gastric and, causes memory difficulty in 10-20% of older people.

When you reflect back to point number 1, that a significant majority of people in nursing homes have serious medical illness, and to point number 2 that many people have behavior problems, you can see why nursing home residents are on an average of 4 medications apiece. Because of drug interactions, the likelihood that memory, mood and behavior could be made worse by combinations of medications is high. One study by Rovner (American Journal of Psychiatry 145:107-109, 1988) for example, showed that nursing home residents with high levels of anticholinergic activity in their blood were more functionally disabled no matter what their diagnosis (this level reflects the side effect potential of a number of medications).

Here again we are hampered in saying how much of a problem this is by the lack of research. We do know about drug interactions and drug side effects but there is very little research to tell us whether, in fact, such interactions are occurring and whether there might be unsuspected interactions in settings such as nursing homes where people are often quite debilitated and not the types of individuals usually included in studies.

I would like to return to a point made previously: the prescription of medication, be they "medical" or "psychiatric", is an art and a skill. It must be done by trained practitioners who are alert to drug interactions and side effects. This is one of the reasons that the Certification Boards of Internal Medicine and Family Practice have established a special qualification in geriatric medicine and that a similar designation is being considered by the Board of Psychiatry and Neurology. It is crucial that we support the training of physicians in geriatric medicine and geriatric psychiatry. The NIH and NIMH have gotten away from funding training in the past several years because of the perception that physicians who go into lucrative specialties are being subsidized in their study by fellowship stipends. I believe it is improper to apply this reasoning to individuals who go into geriatric medicine and geriatric psychiatry. Indeed, many of my former trainees tell me it is more difficult to "make a living" if one focuses on the elderly than if one focuses on younger individuals. It is imperative that federal funding for training in geriatrics, psychiatry, psychology, nursing and social work be continue.

4. It is important to keep in mind that residents of nursing homes are not a single homogeneous group. While there are many different ways to categorize individuals in nursing homes, I believe an important distinction relates to how long individuals stay in homes. Keller and coworkers (Medical Care, volume 19, 363-9, 1981) among others, have demonstrated that 9% of the residents of nursing homes can be considered short stay residents. These individuals stay an average of 1.8 months and make up 61% of discharges because of the rapid turnover. Long term residents of nursing homes, on the other hand, stay an average of 2.5 years. In the Keller study the best medical predictor of short or long stay was "mental disorders and senility", which predicted long stay. Surprisingly, the condition which best predicted short stay was being bed-fast. In another analysis of the 1977 National Nursing Home Survey, Weissert (Medical Care, 23:333-43, 1984) found that only 8.6% of patients with "mental disorders" were discharged from nursing homes to the community. This was much lower than the percentage discharged to the community of any other medical disorder and clearly less than the 28.3% of nursing home residents overall who were discharged to the community.

These findings point up the importance of current research for curing or preventing common forms of dementia since the number of individuals suffering from dementia is projected to increase astronomically in the coming several

decades. These findings also suggest that efforts to improve nursing home care now should, in large part, focus on improving care of individuals with dementia. I believe that efforts aimed at limiting the number of individuals who go to nursing homes will put an unconscionable burden on to family caregivers who are already providing heroic levels of care at home. It is important to keep in mind that only one-third of individuals in the United states who suffer from dementia are in nursing homes and that those who are in nursing homes are more severely ill and have fewer available family members than those who remain at home. While alternative services such as day care, short term relief services, in-home respite, and home visiting may allow us to delay nursing home placement for these individuals, it is my opinion that at most we can delay nursing home placement by 6 months. The development of alternative services is laudable but a major effort must be made now by the National Institutes on Aging and Mental Health to improve nursing home care. We need to more clearly identify areas of greatest care need in nursing homes; identify better treatments for the unique problems which arise in nursing homes; to improve standards for the practice of various professionals in the nursing home; and provide better training of geriatricians, geriatric psychiatrists and psychologists, nurses, social workers and rehabilitation medicine workers who provide care in American nursing homes.

5. Lastly, I would like to make a point which is radical but reflects the reality of the coming decade: nursing homes are becoming medical/psychiatric hospitals. A trend has been underway for several years now to discharge people from medical hospitals who are still medically ill but who do not require the intensity of care provided by acute hospitals. Some of these individuals are being discharged to nursing homes. At the same time, nursing home residents who develop acute illnesses are increasingly likely to be treated in the nursing home rather than being referred to hospital. In the coming years it is likely that the pressure to treat acute problems on site will increase.

A similar trend is developing in relationship to psychiatric disorder in the nursing home. State mental hospital beds are vanishing and pressure continues to keep even the severely ill in the community. Since a majority of nursing home residents suffer from psychiatric disorder and since pressure is appropriately increasing to treat residents on site--that is, in the nursing home--a greater percentage of nursing home residents will require psychiatric intervention.

What is needed, in my opinion, is a partnership between "medical" and "psychiatric" practitioners at all levels. I do not believe any one professional can be expected to have all the skills required to provide excellent care. Nor do I believe that attempts to artificially designate nursing homes as "psychiatric facilities" if more than 50% of residents have a psychiatric condition or to refuse nursing home admission to individuals who are both depressed and in need of nursing home care will serve the best interest of the patient. Rather, we will best serve nursing home residents by demanding that they receive appropriate care from knowledgeable professionals. The professions must establish standards of practice, the regulators must establish rules which protect patients and actually meet a need and researchers must turn their attention to interventions which will improve care.

In summary, I want to note that there are many excellent nursing homes in this country and many homes which are an embarrassment to us all. We must guard against easy bureaucratic fiats issued by individuals who know nothing about the medical/psychiatric problems of nursing home residents but rather demand that regulations on nursing home care be based on what we know about people who live in nursing homes. The professions should be pushed to develop standards of care and practitioners be expected to live up to these. Responsible actions such as these can lead to a dramatic improvement in nursing home care without huge expenditures. The best measure of services would be an attitude change in the U.S. so that practitioners of nursing home medicine can say with pride that they work in a nursing home and families can say with pride that they have placed their loved one in the setting best suited for them.

Chairman STARK. Dr. Beers.

STATEMENT OF MARK H. BEERS, M.D., ASSISTANT PROFESSOR OF MEDICINE, DEPARTMENT OF MEDICINE, DIVISION OF GERIATRIC MEDICINE, UNIVERSITY OF CALIFORNIA AT LOS ANGELES

Dr. BEERS. Thank you, Chairman Stark and members of the committee. My name is Mark Beers, Assistant Professor of Medicine at the University of California, Los Angeles in the division of geriatric medicine. And I come to bring you an internist's point of view.

I am also here as part of the other front of the war on drugs. When I used the word, "medication," as in psychoactive medication, we all tend to think of the good that these chemical compounds do. But when I use the word, "drugs," I hope that you will think about the suffering that their abuse leads to.

I am talking about psychoactive drugs or medications that affect the mind. They are used by physicians to treat anxiety, sleeplessness, nervousness, hallucinations and depression, but in the nursing home they are most often used to treat the 50 to 70 percent of demented people who have behavior problems. These behavior problems are intolerable to the institution and include such things as noisiness, uncooperativeness, wandering and agitation.

There are three problems associated with the use of these medications. First of all. They don't work all that well. The information published to date, especially in the demented elderly show that these medications don't work well except in that they sedate, that is, they put people to sleep. There is a small subset of the population that really benefits from their other effects.

Second, and very importantly, is that these medications are toxic. Their toxicity is common and it is severe. They oversedate and lead to increased dependency and care needs. They can cause depression. They can cause confusion. They can cause gate problems, falls and fractures, movement disorders like Parkinson syndrome, urinary retention, and blurred vision.

The use of these medications may mask medical and psychiatric illness. The sedated patient may be depressed. The agitated patient may have medical illness that requires treatment.

Let me paint a quick picture for you about how bad the problem is. We studied 850 patients in the Greater Boston area. We found that two-thirds of the nursing home residents had orders for these medications and over half used them regularly. In fact, one in five patients had orders for two or more at the same time. And equally disturbing, over half of these prescriptions were written to be used "as needed", thereby deferring to the nursing staff on when to use them.

We looked at three specific categories of medications and found that one-third of patients were ordered for antipsychotic medications, the most toxic class of psychoactive medications, although only 13 percent of these had any diagnosis hat could justify their use.

When we looked at sedative hypnotics we found that 40 percent were ordered to get these medications and that in over 20 percent of these prescriptions, the wrong medication was chosen for the el-

derly. We also looked at antidepressants and found 14 percent of the nursing home residents prescribed these medicines, which is not troubling because we know that depression is very common. The problem was that 25 percent of those receiving antidepressants were receiving the worst medication for the elderly.

In summary, these drugs are prescribed much more frequently than they should be, and they are prescribed by internists and family practitioners, not by psychiatrists. Doctors often prescribe these medications in a way that defers to the nursing staff on when to use them and doctors frequently fail to prescribe the safest medication even when a medication is needed.

Thus, patients are overmedicated and mismedicated. As I have tried to think of ways to fix this problem, both as a clinician and as a researcher, I have identified what I think are three causes. The first is poor education on the part of doctors and nurses who think that these medications work better than they do and who do not know that they are not as toxic as they are. And as I asked myself who is best equipped to teach practicing physicians on how to use these medications, I, like you, have to ask the question: Is it the psychologist, psychiatrist or consulting geriatrician? I am not yet convinced that that task is best accomplished by the psychologist, but I am not sure, and I offer to you that that can be tested experimentally before you fund a legislation.

There are also institutional needs; that is, the institution needs to take care of patients quietly and carefully, and we have to ask ourselves who is best equipped to offer alternative forms of treatment. Is it the psychologist, the social worker or is it those people who keep the elderly active in nursing homes and thereby give them physical and mental stimulation? And finally, I have to ask how can we make physicians more efficient and better able to prescribe new medications in the nursing home and how we are going to accomplish this from a protocol point of view.

In summary, I think that the abuse of medication in nursing homes is a major aspect of quality of care. And as long as this continues to exist, we may dilute our ability to help the elderly residing in nursing homes who may have otherwise treatable illnesses. And we increase the cost of care by the overuse of these medications and certainly continue to decrease the quality of life for those residing in nursing homes.

I thank you.

[The statement of Dr. Beers follows:]

STATEMENT SUBMITTED TO
THE HOUSE WAYS AND MEANS COMMITTEE
SUBCOMMITTEE ON HEALTH

PSYCHOACTIVE MEDICATION USE IN NURSING HOMES

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March 6, 1989

Nearly a decade ago, Congress heard testimony describing the serious problem of psychoactive medication use in institutionalized elderly.[1] I am here today to share information that indicates that the problem has gotten worse. The overuse of these medications and the poor choice of individual drugs remain major contributions to the psychological and functional impairment of elderly residents in nursing homes.

Physicians use psychoactive medications to sedate, to induce sleep, to treat depression and anxiety, and to control behaviors often associated with dementia. When used judiciously they can be effective treatment, and when prescribed and monitored intelligently their side-effects can be minimized. The problem with their use is that they are commonly overused and frequently lead to serious side-effects.[2,3,4] Those side-effects include confusion, over-sedation, unsteady gait, dizziness, falls and fractures, movement disorders such as Parkinson's Syndrome, inability to pass urine, and blurred vision. Not only are these medications overused, they are also misused; that is, even when a medication is needed, physicians often fail to chose the safest and most effective drug, thereby adding unnecessary risk without additional benefits.

The overuse and misuse of psychoactive medications in nursing homes are among the most serious quality of care issues for the institutionalized elderly. By robbing the most frail elderly of further physical and mental function, these medications condemn some to a life of increased dependency, diminished enjoyment, and decreased participation. By causing side-effects that lead to injury and a need for increased care, they may increase the cost of caring for nursing home residents.

Additionally, it is likely that the wide-spread overuse and misuse of psychoactive medications add to the psychological woes of nursing home residents. First, when used inappropriately they may cause depression, agitation, sedation, and confusion. Second, they may mask psychological disease and make depression, anxiety, and confusion difficult to recognize. As long as these medications are overused, the impact of increased non-pharmacological mental health services may be lessened.

The Results of Research

The results described here are from a study published in the Journal of the American Medical Association in November, 1988 and funded by the John A. Hartford Foundation.[5] These results describe the use of psychoactive medications in 12 nursing homes in the Boston area in 850 subjects over a one month period in 1986. These nursing homes were generally representative of all homes in Massachusetts, and our data probably describe the average, or slightly better than average, care delivered nationwide. This study excluded nursing homes known to have large numbers of patients who had been discharged from mental health institutions. We

examined the prescription of psychoactive medications (Doctor's orders) and actual use of these drugs. We defined actual use as the use of a medication at least 5 times during one calendar month.

Nearly two-thirds of all subjects had orders for at least one psychoactive medication, and 53% actually used them. More than 20% had orders for 2 or more psychoactive medications, and 7% had orders for 3 or more. Nearly half of these orders were written "as needed;" thus, the decision to actually use these drugs was left to the nursing staff rather than to physicians.

We were particularly interested in the class of medications called antipsychotics and which have also been called neuroleptics or major tranquilizers. These medications, the most familiar of which are Haldol (haloperidol) and Mellaril (thioridazine), commonly cause serious toxicity, including some side-effects that do not resolve if the medication is stopped.[6] These drugs were invented to control psychosis, such as treating hallucinations and paranoia in schizophrenic patients. They received extensive publicity when the public learned about their wide-spread use to treat non-psychotic patients in state mental institutions. Nonetheless, they are still commonly used to treat non-psychotic demented persons in nursing homes without informed consent, even though there are no good data to establish that they are effective for treating behavior disorders.[7,8,9,10] In fact, there are no data to show that they are better than some safer alternatives for treating non-psychotic persons suffering from dementia who might wander, make noise, cooperate poorly, or have insomnia. That they are toxic is not in doubt.[11,12]

We found that one-third of patients had orders for antipsychotic medications, and more than one-quarter actually used them. Only 13% of the people who had orders for these medications had a diagnosis that might indicate psychotic behavior. Most of those who received them suffered from dementia.

The medications used to treat anxiety and insomnia are often interchangeable, and we studied them together. Forty percent of patients were prescribed these medications, and slightly more than one-quarter used them. Of equal importance, however, were the individual medications chosen by the prescribing physicians. As we have learned more about the physiology and pharmacology of aging, we have learned that certain medications should be avoided in the elderly because they last too long or cause avoidable side-effects. Nearly one in five people prescribed a sedative was given one of the long-acting benzodiazepines that geriatricians have stated should not be used in the elderly, and one-quarter received diphenhydramine (Benadryl) another medication that should be avoided in the elderly. Thus, not only did patients receive sedatives frequently, but when they did, they often did not receive the safest choice.

We found the same serious error of choice for antidepressants. Fourteen percent of patients received antidepressants and this may well be within the range of expected appropriate use. However, amitriptyline (Elavil) the antidepressant that is the least desirable for the elderly because of side-effects was prescribed to more than a quarter of all those using antidepressants.

In summary, our survey showed that doctors prescribe psychoactive medications frequently and that nursing home residents used them commonly. Many patients received more than one such drug. The quantity of prescriptions for these drugs suggested serious overuse of sedative/hypnotics and

antipsychotics. Doctors frequently wrote orders "as needed," thereby allowing the nursing staff to decide when to use the drugs. Doctors commonly prescribed medications with more frequent and more serious side-effects and which the medical literature states should be avoided in the elderly suggesting serious misuse.

Implications

In an editorial accompanying our article,[13] Dr. Don Riesenberg posited the question, "Drugs in the Institutionalized Elderly: Time to get it right?" With over 1.1 million older Americans in nursing homes[14] and a bill for that care which is over twenty billion dollars yearly,[15] does it make sense to overmedicate?

From the point of view of quality of care, it is important to strive to keep each individual as functional, involved, and independent as is possible even in the nursing home. From the point of view of cost, it is also important to strive to keep people functional and independent. From the point of view of mental health, it is important to treat only when warranted, to chose the safest and best medication, and to be able to recognize treatable psychiatric illness. There is every indication that the overuse and misuse of psychoactive medications in the nursing home work against these ends. Where then might the solutions lie?

The first need is for improved education of the doctors and nurses who deliver care, under extraordinarily difficult circumstances, in nursing homes. The other need is for incentives to review and discontinue psychoactive medications in the nursing home. As long as the power to start, stop, and use these medications remains in the hands of doctors and nurses, interventions should target physicians and nurses. But, as long as it is easier and cheaper to prescribe medications rather than to decrease their use and involve nursing home residents in increased activities and better personal care, the problem may remain unsolvable.

There is no doubt that there are many unmet needs in our current system of caring for the institutionalized elderly. Our data suggest that an important focus of our attention should be the overuse and misuse of psychoactive medications in the nursing home. It is a sad aspect of the care of the institutionalized elderly in America that in the last months and years of life, so many will be given medications that impair their ability to think and to participate, that make them shake and become stiff and unable to walk, and that make them dizzy when they stand and fall and fracture their bones. In the final analysis these medication are too often given to meet the needs of the institution housing them rather than to help elders live their lives in comfort and with dignity.

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Psychoactive Medication Use in Intermediate-Care Facility Residents

Mark Beers, MD; Jerry Avorn, MD; Stephen B. Soumerai, ScD; Daniel E. Everitt, MD; David S. Sherman, RPh; Susanne Salem, MHSA

Despite the large number of elderly patients in nursing homes and the intensity of medication use there, few current data are available on patterns of medication use in this setting. We studied all medication use among 850 residents of 12 representative intermediate-care facilities in Massachusetts. Data on all prescriptions and patterns of actual use were recorded for all patients during one month. On average, residents were prescribed 8.1 medications during the month (interquartile range, 7.4 to 8.8) and actually received 4.7 (range, 4.2 to 5.4) medications during this period. More than half of all residents were receiving a psychoactive medication, with 26% receiving antipsychotic medication. Twenty-eight percent of patients were receiving sedative/hypnotics during the study month, primarily on a scheduled rather than an as-needed basis. Of patients receiving a sedative/hypnotic, 26% (range, 14% to 41%) were taking diphenhydramine hydrochloride, a strongly anticholinergic hypnotic. Of those receiving one of the benzodiazepines, 30% were receiving long-acting drugs, generally not recommended for elderly patients. The typical benzodiazepine dose was equivalent to 7.3 mg per patient per day of diazepam. The most commonly used antidepressant was amitriptyline hydrochloride, the most sedating and anticholinergic antidepressant in common use. These data indicate that despite growing evidence of the risks of psychoactive drug use in elderly patients, the nursing home population studied was exposed to high levels of sedative/hypnotic and antipsychotic drug use. Suboptimal choice of medication within a given class was common, and use of standing vs as-needed orders was often not in keeping with current concepts in geriatric psychopharmacology. Additional research is needed to assess the impact of such drug therapy on cognitive and physical functioning, as well as to determine how best to improve patterns of medication use in this vulnerable population.

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ON ANY given day, there are more people in nursing home beds than in acute-care hospital beds in the United States.[1] Although nursing home residents are among the most intensely medicated patients,[1] little is known about the details of drug prescription and use in this large population of institutionalized elderly persons. This article describes a large-scale study of all medication use in 850 residents of 12 representative Massachusetts nursing homes. It represents one of the few detailed surveys of medication use performed in the last decade with a large cohort of long-term–care residents.

For editorial comment see p 3054.

In 1976, the Office of Long-Term Care of the Department of Health, Education, and Welfare published one of the first comprehensive studies of medication use in such a population, based on a sample of 3458 nursing home patients covered by the Medicaid and Medicare programs.[2] The report suggested serious problems of overuse and misuse of drugs in this population. Patients were found to be taking an average of 6.1 drugs, and nearly 50% of all residents were prescribed tranquilizers (a category that included antipsychotic medications and minor tranquilizers). Approximately 12% of all residents were prescribed two or more psychoactive drugs, with antipsychotic medications prescribed much more often than minor tranquilizers. About one third of all patients were prescribed sedative/hypnotics, and 9% were taking antidepressants. Of those receiving antidepressants, 38% were prescribed amitriptyline hydrochloride.

In a more recent study reviewing Medicaid patients residing in nursing homes in Tennessee, Ray et al[3] found that 42% of those patients received antipsychotic medication. The authors concluded that their findings provided "epidemiologic evidence suggesting misuse of antipsychotic drugs in nursing homes." Further accounts of the overuse of psychoactive drugs in nursing homes were presented during widely

reported congressional hearings in 1980.[4]

Data collected regarding drug use in nursing home patients have relied on computerized databases that focused on Medicaid and Medicare patients. Although these sampling methods have the advantage of including large numbers of patients, they exclude half of long-term–care patients who pay for nursing home care through their own resources and, thus, may not be representative of the nursing home population in general. In addition, most studies have not collected data on actual use of as-needed (*pro re nata* [PRN]) orders, and so have not been able to measure the intensity of use of medication administered through this common nurse-mediated and very variable mechanism. Smaller studies have examined drug use in a single nursing home[5-7] and may not be generalizable.

During the past decade, considerable evidence has accumulated and been published concerning the dangers of polypharmacy in elderly patients.[1,8] Recommendations have included restrained use of medications, particularly those affecting the central nervous system, and the substitution of safer alternatives for many older drugs. Amitriptyline, the first available tricyclic antidepressant, is highly sedating and anticholinergic, two properties that often make it undesirable for elderly patients. Newer and safer antidepressants are now available and preferable. Diphenhydramine hydrochloride, an antihistamine with strong sedating properties, has been commonly used to induce sleep in the nursing home setting, but it too is strongly anticholinergic and, thus, is not a drug of choice for elderly patients.[9] Flurazepam hydrochloride, diazepam, and chlordiazepoxide hydrochloride, the older benzodiazepines with very long half-lives in elderly patients,[10-12] have been shown to present the risk of increased toxicity in aged patients; newer, shorter-acting benzodiazepines are generally preferable when benzodiazepines are needed.[11]

Increasing numbers of studies of toxic reactions to psychoactive drugs in elderly patients have demonstrated associated morbidity, including a high incidence of acute confusional states,[13] hip fractures,[14] and oversedation. The clinical literature on antipsychotic medications has failed to show specific benefit for most nonpsychotic elderly patients,[15-17] although their toxicity has been well documented.[18] There is good evidence that these drugs have been seriously overused in nursing home patients.[19]

Although the knowledge base of geriatric pharmacology has improved and such information has become more available, there have been remarkably few large-scale data published on patterns of medication use, and particularly on psychoactive drug use, in nursing homes in recent years; nor has there been any systematic evaluation of the impact of developments in geriatric research and teaching on actual practice in long-term–care facilities. This study was designed to explore this important but poorly documented aspect of the health care system.

METHODS

In developing a targeted educational intervention aimed at improving drug use in nursing homes, we studied baseline patterns of medication use among residents of 12 representative intermediate-care facilities (ICFs) in Massachusetts. A complete list of all ICFs in Massachusetts was obtained from the Massachusetts Department of Public Health. Because the eventual goal was to provide an educational intervention, homes with fewer than 40 ICF-level residents were excluded. We identified 339 homes in Massachusetts that met this criterion; those in eastern Massachusetts were considered for further study. To ensure that the homes represented typical geriatric facilities rather than those caring for deinstitutionalized mental hospital patients, homes were eliminated if they had greater than 20% of their residents admitted from inpatient psychiatric hospitals. Homes with active nurse practitioner prescribing were likewise excluded, as were facilities with preexisting relationships between the authors and consulting pharmacists or physicians in the homes. The remaining 26 homes were given information about the drug-use intervention. Ten homes declined to participate in a randomized trial, primarily because of changes in ownership or administration or labor disputes. Of the remaining 16 homes, 12 were enrolled in the study and four were retained as alternates on the basis of geographic distribution. A pilot survey of drug use over a two-week period revealed no difference in average use of antipsychotic and sedative drugs between the study homes and the alternate homes.

Data Collection and Analysis

An interactive data collection program was written to guide research assistants in capturing medication-use data on a portable computer. In each facility, all medication data were recorded for all residents for an entire month. For all drugs prescribed, the program prompted for data regarding medication name (trade or generic), current regimen, dosage changes, start and stop orders, route of administration, and other changes in regimen during the month. A PRN use module made it possible to document the doses of PRN medications actually administered each day and sum them over the month. The software combined data on a given drug recorded as either its generic or trade name, as well as summing scheduled doses and PRN doses actually administered. Additional programming made it possible to convert regimens into equivalent milligrams of a prototype compound for each group (eg, chlorpromazine hydrochloride or diazepam), as well as analyze use by broad categories of drug (eg, all antipsychotic medication). In addition, the program also recorded the name of each patient's physician, the patient's age, sex, date of admission, payment source, current diagnoses, and the date and reason for hospitalizations that occurred during the study period.

Data were collected regarding all patients residing in the 12 study homes (n = 850). More than half (n = 441) of the study subjects were Medicaid patients. Because nursing homes rather than patients were sampled, analyses were performed with the nursing home as the unit of analysis. In addition, to control for the potential influence of outlier facilities and to make our results more generalizable to other ICFs, we measured drug utilization as the median and interquartile range of the measures of drug use. This method is more conservative when there are significant interhome differences in specific usage categories. To avoid considering drugs written for PRN use but not given, medications are described as having been "used" only if they were administered to the patient on at least five days in the study month.

Nursing Homes Sampled

To ensure that the homes studied were representative of ICFs throughout the state, we compared all available characteristics of each of the 339 Massachusetts ICFs that had 40 or more beds with those of the study homes, as indicated in Table 1. The study homes were found to be quite similar to the universe of homes regarding patterns of ownership and management; as noted in Table 1, about 70% of Massachusetts homes with intermediate-care beds are owned and operated by for-profit corporations. Additional data for nonstudy homes were obtained from the Massachusetts Department of Public Health. Table 2 shows that the homes studied were comparable with all ICFs of similar size

within 96 km (60 miles) of Boston with respect to the proportion of residents on Medicaid, under age 65 years, and over age 85 years.

RESULTS

Demographics and Overall Drug Use

The total sample consisted of 850 patients in 12 facilities; the median home had 70 patients, with an interquartile range of 60 to 80 patients. Unless otherwise stated, all results reported herein are the median of the 12 nursing home proportions or means; the interquartile ranges are indicated in parentheses.

As in most nursing home populations, the majority of residents, or 84% (range, 76% to 87%), were female; their mean age was 85 years (range, 84 to 96 years). Sixteen percent of patients were male, with a mean age of 82 years (range, 76 to 84 years). Of all drug orders written, 48% (n = 7168 orders; range, 37% to 52%) were written for PRN use.

The average number of different medications ordered per patient during the month was 8.1 (range, 7.4 to 8.8). One fifth of all prescriptions were for over-the-counter analgesics and cathartics. Analysis of drugs actually given at least once each month and those given on at least five days each month demonstrated that patients received 5.5 (range, 4.7 to 6.0) or 4.7 (range, 4.2 to 5.4) different medications on average, respectively. Since these estimates included occasional short-term therapies (eg, antibiotics), the average number of concurrent drugs per day would be slightly lower. Only 35 patients (4%) had no medication orders. There was no significant difference in overall drug use between men and women.

Psychoactive Drug Use

Nearly two thirds of the residents (65%; range, 58% to 71%) had orders written for one or more psychoactive medications, and 53% (range, 48% to 59%) actually used psychoactive drugs on five or more days during the study month (Table 3). These included sedative/hypnotics (including benzodiazepine tranquilizers), antipsychotics, and antidepressants. Barbiturates, antiseizure medications, antiparkinsonian drugs, lithium carbonate, and antihypertensives with known psychoactive properties were not included. Forty-three percent of orders (range, 35% to 48%) written for psychoactive drugs were written for PRN use, but only 20% of those PRN orders were used. There was no difference between Medicaid and non-Medicaid patients in overall psychoactive drug use or in any subcategory of drug use.

Table 1.—Characteristics of Study Homes and All Massachusetts Nursing Homes With 40 or More Intermediate-Care Facility Beds

Characteristics	Study Homes (n = 12)	All Massachusetts Homes (N = 339)
Mean No. of intermediate-care facility beds	75	66
Mean No. of total beds	101	108
Ownership, %		
Individual or partnership	25	14
Nonprofit	8	12
For-profit corporation	67	72

Table 2.—Patient Characteristics (Means) in Study Homes and All Massachusetts Nursing Homes With 60 or More Intermediate-Care Facility Beds*

Residents	Study Homes, % (n = 12)	All Massachusetts Homes, % (n = 109)
On Medicaid	62 (SD = 26)	73 (SD = 23)
From psychiatric institutions	0	3 (SD = 9)
< Age 65 y	4 (SD = 6)	8 (SD = 12)
> Age 85 y	49 (SD = 10)	43 (SD = 14)

*Study homes are compared with all Massachusetts nursing homes with 60 or more intermediate-care facility beds within 96 km (60 miles) of Boston; based on data provided by the Massachusetts Department of Public Health.

Table 3.—Patterns of Prescription and Actual Use of Psychoactive Medications* in 12 Nursing Homes (850 Patients)

No. of Psychoactive Drugs	Medications Ordered, Median % (Interquartile Range)	Medications Used,† Median % (Interquartile Range)
0	34.9 (29.1-41.5)	47.1 (40.9-52.4)
1	38.8 (32.4-41.9)	32.9 (29.9-39.3)
2	20.6 (19.0-26.3)	15.2 (12.8-20.1)
≥3	6.6 (1.3-8.7)	2.6 (0.0-4.3)

*Includes antipsychotics, sedative/hypnotics, and antidepressants only.
†Patient received drug at least five days in study month.

Table 4.—Psychoactive Drug Use by Residents With Specific Diagnoses

Diagnosis	All Patients	No. (%) of Patients Receiving Any Psychoactive Medication	Receiving Antipsychotic Medication	Receiving Antidepressant Medication	Receiving Sedative/Hypnotic Medication
Organic brain syndrome	150	94 (63)	58 (39)	8 (5)	57 (38)
Alzheimer's disease	228	164 (72)	99 (43)	33 (14)	94 (41)
Schizophrenia/psychosis	51	42 (82)	36 (71)	7 (14)	15 (29)
Depression	116	96 (83)	46 (40)	47 (40)	56 (48)

About one fifth of patients (21%) had orders for two psychoactive medications during the study month; 7% of patients had orders for three or more psychoactive medications. Actual use was somewhat less (Table 3).

Antipsychotic Drug Use

One third of patients (270) had orders written for antipsychotic medications. During the study month, 26% (range, 20.9% to 27.8%) of all residents actually used a neuroleptic on five or more days. Most of these patients had a combination of scheduled neuroleptic prescriptions with additional PRN orders. Of all orders for antipsychotic medication written, 42% (range, 26.6% to 45.5%) were for PRN use, and 58% for regularly scheduled regimens. However, only 11% (range, 0% to 17%) of PRN orders were activated during the study month. Of those patients taking antipsychotics, the median of the average daily dose by home was 65 mg per patient per day (range, 42 to 94 mg per patient per day) in milligram equivalents of chlorpromazine[20-22]; for individual patients, the highest dose observed was 2000 mg per day. Only 36 patients receiving antipsychotic medications carried a diagnosis of schizophrenia or other psychosis; Alzheimer's disease, organic brain syndrome, and depression were each more common diagnoses in these patients (Table 4).

Haloperidol was the most commonly prescribed antipsychotic medication

and was given to 43% (range, 26% to 52%) of those receiving antipsychotics and to 10% of the total sample. Thioridazine hydrochloride was the second most commonly prescribed antipsychotic, given to 33% (range, 25% to 50%) of those receiving antipsychotics and to 7% (range, 6% to 14%) of the total population.

Sedative/Hypnotic Drug Use

Forty percent (range, 34% to 51%) of patients were prescribed sedative/hypnotic drugs, and 28% (range, 23% to 41%) actually used these drugs for at least five days during the study month. Of these, 82% were receiving such a medication on a regularly scheduled basis. Most orders for minor tranquilizers and hypnotics were for regularly scheduled use; while many patients had both scheduled and PRN orders, just 13% of patients prescribed sedative/hypnotics had *only* PRN orders. Twenty-three percent (range, 19% to 31%) of PRN orders for drugs in this class were used.

About one fourth (26%; range, 14% to 41%) of all patients receiving a sedative/hypnotic were prescribed diphenhydramine. Twenty percent (range, 11% to 25%) of all patients and 63% (range, 48% to 74%) of those receiving a sedative received a benzodiazepine. As with sedative/hypnotics in general, the majority of benzodiazepine orders were prescribed as a standing order (87%; range, 64% to 100%). Of those receiving benzodiazepines, 51 patients (30%; range, 15% to 39%) were taking the long-acting drugs flurazepam, diazepam, or chlordiazepoxide; for 67% of these patients, the regimen was a standing order to be administered at least daily. The average consumption of benzodiazepines was 7.3 mg per patient per day (range, 6.7 to 9.5 mg per patient per day) in milligram equivalents of diazepam.[20,21,22]

Antidepressant Drug Use

Fourteen percent (range, 10% to 17%) of patients used antidepressants. These orders were written almost exclusively as regularly scheduled regimens, though two patients received the drug as a PRN bedtime hypnotic. There was no difference between men and women in overall use of antidepressants. While 47 (39%) of the 119 patients receiving antidepressants had a diagnosis of depression recorded, the majority (61%) did not (Table 4).

Of those receiving antidepressants, the largest group (26%; range, 18% to 35%) received amitriptyline. The other antidepressants used were desipramine hydrochloride, doxepin hydrochloride, trazodone hydrochloride, imipramine hydrochloride, nortriptyline hydrochloride, and maprotiline hydrochloride.

COMMENT

These data suggest that despite a growing literature on the risks of polypharmacy in elderly patients, total drug use has remained high in this sample of nursing homes. The Department of Health, Education, and Welfare Office of Long-Term Care study of 1976 found that nursing home residents had prescriptions for an average of 6.1 concurrent medications per patient on the day of the survey. On average, patients in our study homes were prescribed 8.1 different medications during a month. Of these orders, an average of 4.7 drugs were actually used on five or more days by these residents. Though drug-related adverse effects are well publicized and the seriousness of such complications are well known,[4,23,24] those chronically institutionalized elderly patients who are least able to cope with drug side effects appear to be at continued risk for experiencing them.

The nursing homes from which these findings come are reasonably representative of homes in Massachusetts and the Northeast in general. However, there are potential limits to the generalizability of these findings. We studied only intermediate-care patients. These are patients in need of less care than those admitted to skilled-nursing facilities, a selection criterion that would, if anything, tend toward lower medication use. Facilities with high proportions of deinstitutionalized psychiatric patients were not included in the study. On the other hand, the inclusion of all short-term drugs given during the study month (eg, antibiotics) somewhat increases the estimated number of drugs prescribed in comparison with the Department of Health, Education, and Welfare study, which was based on a single-day survey.

The use of PRN medications presents special problems in nursing homes. Such orders place the responsibility of deciding to implement drug therapy on the nursing staff. It has been previously shown that extensive use of PRN medication may adversely affect patient care[26,27] if monitoring is poor and if the nursing staff is not adequately trained in the use and side effects of such drugs. Some authors have also suggested an increased cost to the institution when PRN orders are overused.[27] The data presented herein document a very high level of PRN ordering of psychoactive medications, of concern in a level of care (ICF) with fewer requirements for the presence of skilled nursing surveillance. Nearly half of all orders for psychoactive drugs were written for PRN use. In practice, nurses initiated use of only about one fifth of these PRN orders. Ironically, in those situations in which PRN use is generally preferred over regularly scheduled use (eg, as sedative/hypnotics), the data indicate that PRN use accounts for only a small fraction of drug administration.

In this study, over half of all patients were receiving psychoactive drugs; about one in four patients was taking two or more psychoactive medicines. Reliance on scheduled regimens of psychoactive medicines indicates that these drugs are not used transiently for periods of special need. Instead, this pattern of use is compatible with the concept of sedation as "chemical restraint."[28]

In many cases, the best drug within a therapeutic class was underutilized. This is exemplified by the high use of diphenhydramine as a hypnotic, a drug with strong anticholinergic properties[5] that can lead to confusion and worsening of dementia, constipation, and urinary retention.[18,29] Likewise, nearly one third of those who received benzodiazepines were prescribed older, long-acting drugs that are known to accumulate in elderly patients[17,30,31] and are associated with a high frequency of toxic reactions in this age group.[32] These findings differ from that of James,[33] who found a level of use of hypnotics much lower than this study did, and lower than that reported in the rest of the literature. He attributed this difference to more vigorous drug utilization review in the five facilities that agreed to participate in his survey.

Amitriptyline, the antidepressant with the highest anticholinergic and sedating properties,[17,34] and least favored for geriatric patients,[35] was given to about one fourth of those taking an antidepressant, despite the availability of medications less toxic for elderly patients, such as the secondary amines. (This percentage of use is comparable with that reported in 1976, although the 1976 analysis of the Office of Long-Term Care considered perphenazine as an antidepressant, somewhat lowering the percentage of amitriptyline use.)

The usefulness of antipsychotic medications in nonpsychotic, elderly patients has been questioned,[14,15] although these drugs represent a common approach to the very difficult problem of managing disruptive behavior in demented patients who may be a risk to themselves or others. The high frequency of toxic reactions to these drugs is well documented, with many older patients who take them experiencing orthostatic hypotension, Parkinson's syn-

drome, tardive dyskinesia, akathisia, worsened confusion, dry mouth, constipation, oversedation, and urinary incontinence.[11,16,17] Although the total use of these drugs in this study is slightly lower than that in earlier reports, previous studies included many chronically institutionalized psychotic patients, estimated to make up at least 8% of all nursing home residents[36]; these patients were in large part excluded from our sample.

These findings indicate that there is need for considerably more effort to improve the use of psychoactive drugs in institutionalized elderly patients. Psychoactive medications continue to be used with high frequency and selection of drug is often suboptimal. Further analysis is required of the factors that influence drug use in nursing homes. Many of these may represent problems of inadequate staffing as well as information deficits among prescribers. There is a pressing need to study the clinical impact of such high levels of psychoactive drug use in this population to determine whether more judicious use of medications would result in reduced levels of disability in these already impaired elderly patients.

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Chairman STARK. Thank you. Dr. Billig.

STATEMENT OF NATHAN BILLIG, M.D., PROFESSOR, DEPARTMENT OF PSYCHIATRY, AND DIRECTOR, CENTER ON AGING, GEORGETOWN UNIVERSITY MEDICAL CENTER

Dr. BILLIG. I am a professor in the department of psychiatry at the Georgetown University Medical School; also the director of the center on aging and director of the geriatric service there, and I am the author of a book, "To Be Old and Sad," which talks about depression in the elderly, the most common psychiatric problem that we encounter in our day-to-day practice.

In my written testimony, I developed a case scenario of Mrs. A, a well-functioning woman who, in spite of some chronic illnesses and multiple medications, thought she had coped well with her husband's decline from Alzheimer's disease and heart disease over the past 5 years.

She became aware soon after his death that she had increasing memory losses, and feelings of unremitting sadness. She would forget to take in the newspaper in the morning, to lock up the house at night, to take some of her medications.

She was unsure of some recipes she had used for 40 years. She had more trouble falling asleep at night, would wake up several times and wake up earlier than she was used to. She was tired during the remainder of the day and felt decreased motivation. On several occasions, she forgot to turn off the gas stove. She grew increasingly fearful that she had Alzheimer's disease, the disease that her husband had died with.

She was somewhat more fortunate than many of the old people we see because she had enough retirement income to lead a stable life. She worried that a medical illness would bankrupt her. Mrs. A represents a fairly typical referral to my clinic at Georgetown. She, like most of the people we see, has been well-functioning for many years in spite of being 70 or 80 years of age, significant medical problems which she has gotten them treated. She suffered the loss of her husband and now lives alone.

She is dealing with increasing symptoms of forgetfulness, depression and decreasing function over the past year. This constellation of history, signs and symptoms, presents the physician and his consultants with the difficult task of assessing all the medical and psychiatric problems, evaluating each fully, making a diagnosis, devising a treatment and monitoring the execution of that plan over time. It is far too simple to ascribe her deterioration to just a grief reaction. The list of possible medical and psychiatric diagnosis even in a case that sounds simple like this one, is not.

No one has mentioned the demographics of the population that we are dealing with today. People over 65 now represent over 12 percent of the U.S. population, more than 30 million people.

The group over 75 accounts for over 12 million people, 41 percent of the total over 65 population. And this later group is the fastest growing segment of our entire U.S. population. While most older adults are living independently in spite of chronic illnesses, the prevalence of psychiatric illness in this population is significant.

Depression is the most common psychiatric problem, seen by general medical professionals and psychiatrists, while it spans the spectrum from mild to severe. It can radically alter the functioning of an otherwise healthy older person in terms of their activities of daily living, self-care and general medical health; in fact, in terms of survival.

Depression in the later years is unfortunately often attributed by both laymen and many professionals to just getting older. Depression and other mental or physical disorders are not part of normal aging. Whenever an illness is identified, it should be evaluated and treated. It is ironic that depression, while being underestimated, is one of the most successfully treated medical disorders, with medications and psychotherapy.

Alzheimer's disease, as Dr. Rabins mentioned, affects between 5 and 10 percent of the population and maybe as high as 20 percent of the group over 80 years. Alzheimer's disease is the most common form of dementia, not only affects the patients, but also profoundly affects spouses, children and grandchildren.

The gradual deterioration of cognitive functioning with frequent coincident psychiatric symptoms of agitation, depression and delusions challenges the coping skills of patients and care-givers, also resulting in the need for extensive home care, residential and institutional care.

While these two illnesses represent the primary psychiatric illnesses of late life, older people are not immune to the disorders of younger adults, including anxiety states, schizophrenia, adjustment disorders and other organic mental states.

One of my research interests is the relationship between medical and surgical problems and their psychiatric sequelae. Older adults because of specific vulnerability, seem to be more affected by the adverse effects of medications and biomedical illnesses. In no other age group is the relationship between mind and body so striking.

Older people frequently have psychiatric symptoms of anxiety, depression and cognitive changes as early signs of physical illness and likewise physical symptoms are not uncommon in the complex picture of psychiatric disorders.

All of this speaks to the necessary integration of multiple medical disciplines in the diagnostic phase and the availability of well-trained physicians, primary care physicians and specialists in the treatment phase.

Psychiatric disorders are treatable regardless of age and the complexity of medical and social situations. I wanted to comment on the issue of geriatric psychiatrists. The field is relatively new. It is a distinct and growing specialized body of knowledge with specific assessment and treatment skills.

There are now almost 1,000 members of the American Association for Geriatric Psychiatry, psychiatrists who are specially trained or who have a strong interest or experience in geriatrics. The numbers are far inadequate to deal with the millions of Americans who benefit from diagnosis and treatment from a psychiatrist.

The American Board of Psychiatry and Neurology has approved an added qualification in generic psychiatry to begin in approximately 2 years. Ironically, funding for training programs in geriat-

ric psychiatry is no longer available from the National Institute of Mental Health, so the number of people eligible for certification in the future is severely limited.

Congress has seen geriatrics and mental health issues in particular as important areas for research. Much needs to be learned about the psychiatric illnesses that prevent older people from living productive, enjoyable and independent lives. In spite of some recent changes, reimbursement for psychiatric services has lagged significantly and patients like Mrs. A, in the example above, may not be able to afford to have a potentially treatable disorder treated.

Thank you very much.

[The statement of Dr. Billig follows:]

Testimony Before the House of Representatives
Ways and Means Committee, Health Subcommittee
March 6, 1989

Nathan Billig, M.D.
Professor, Department of Psychiatry
Director, Center on Aging
Georgetown University Medical Center
Washington, D.C. 20007

Mrs. A. is a 75 year old widowed woman who comes to the geriatric psychiatry clinic with the complaint of increasing memory loss and depression over the past year, since the death of her husband. Mrs. A. is treated by her internist for arthritis, mild hypertension, a rhythm disturbance of her heart and adult-onset diabetes. She takes five prescribed medications for these conditions for a total of 15 pills per day. In addition she takes a multivitamin tablet and an occasional tranquilizer which she "borrows" from her deceased husband's collection of pills.

Mrs. A. has been a well-functioning woman who prided herself on reading the Washington Post daily, keeping up on current events, caring for her home, managing family finances, enjoying monthly trips downtown to a museum or to the Kennedy Center, and at least once each summer, she had enjoyed driving to Baltimore with her late husband to visit the harbor and go to a baseball game. She felt that she coped well with her husband's decline with Alzheimer's disease and heart disease for over five years.

Soon after her husband's death she became aware of memory lapses and feelings of unremitting sadness. She would forget to take in here newspaper in the morning, to lock up the house at night, to take some of her medicines, and was unsure of some recipes she had made for over 40 years. She also had more trouble falling asleep at night, was awake several times during the night with difficulty falling back to sleep, and was up for the day at 5 A.M. She felt tired during the remainder of the day and had decreased motivation to participate in social and other activities. On several occasions she forgot to turn off the gas after cooking. She grew fearful that she couldn't remember things that she should, and felt that she might embarrass herself with friends. She worried that she might have Alzheimer's disease and approached the clinic for an evaluation. Mrs. A. is more fortunate than many people her age because she has sufficient retirement income to manage a stable life; she worries that a medical illness will bankrupt her.

Mrs. A. represents a typical referral to my clinic. She, like most people her age, has been well-functioning in spite of a number of significant medical problems for which she is treated.

She has suffered the loss of her husband and now lives alone; she takes multiple medications, has increasing symptoms of forgetfulness and depression, and has decreased functioning over the past year. This constellation of history, signs and symptoms presents the physician and his consultants with the difficult task of assesssing all the possible medical and psychiatric problems, evaluating each fully, making diagnoses, devising treatment plans and monitoring their execution over time.

People over 65 years now represent over 12% of the U.S. population, more than 30 million people. The group over 75 years accounts for over 12 million people (41% of the total over-65 population). This latter group is growing at a faster rate than any other segment of the U.S. population.

While most older adults are generally living independent lives in spite of some chronic illness, the prevalence of psychiatric illness in this population is significant. Depression, the most common psychiatric problem seen by general medical professionals and psychiatrists, is a frequently undiagnosed, misdiagnosed and often untreated illness of the later years. While it spans a spectrum from mild to severe, it can, radically alter the functioning of an otherwise healthy older person so that activities of daily living, self-care, general health and, in fact, survival are threatened.

Depression in the later years is unfortunately often attributed by both laymen and many professionals to "just getting older." Depression and other mental or physical disorders are not parts of normal aging. Whenever an illness is identified, it should be evaluated and treated. It is ironic that depression is one of the most successfully treated medical disorders at any age; up to 75% of those treated have remisssion of symptoms.

Alzheimer's disease, a catastrophic illness of the later years, affects between 5% and 10% of the population over 65 years. Its prevalence increases with age and up to 20% of people over 80 years may be affected. Alzheimer's disease, the most common form of dementia, not only affects the patients afflicted, but has profoundly negative effects on spouses, children and grandchildren. The usually gradual deterioration of cognitive functioning with frequent coincident psychiatric symptoms of agitation, depression, and delusions challenges the coping skills of patients and caregivers, often resulting in the need for extensive home care or residential and institutional care outside the family situation. Ideal medical care necessitates the inclusion of consultations from multiple medical specialties.

While these two illnesses represent the primary psychiatric problems of late life, older people are not immune to the many disorders of younger adults including anxiety states, schizophrenia, adjustment disorders, and organic mental illnessses. One of my research interests is the relationship between medical and surgical conditions and psychiatric

complications of these. Older adults, because of specific vulnerabilities, seem to be affected more by the adverse effects of medications and by medical illness. In no other age group is the relationship between mind and body so striking. Older people frequently have psychiatric symptoms of anxiety, depression and cognitive changes as the early signs of physical illness, and likewise, physical symptoms are not uncommon in the complex picture of psychiatric disorders in this population.

All of this speaks to the necessary integration of multiple medical disciplines in the diagnostic phase and the availability of well-trained primary care and specialized physicians in the treatment phase. Psychiatric disorders are "treatable" illnesses, regardless of age and the complexity of the medical and social situations. The field of geriatric psychiatry is relatively new. There is a distinct and growing specialized body of knowledge and specific assessment and treatment skills. There are now almost 1000 members of the American Association for Geriatric Psychiatry, psychiatrists who are specifically trained or who have a strong interest or experience in geriatrics. The numbers are inadequate to deal with the millions of Americans who could benefit from diagnosis and treatment from a psychiatrist. The American Board of Psychiatry and Neurology, Inc. has approved an added qualification certification in geriatric psychiatry to begin in two years. Ironically, funding for training programs in geriatric psychiatry, is no longer available from the National Institute of Mental Health, so the number of people eligible for certification in the future is severely limited.

Congress has seen geriatics, and mental health issues in particular, as important areas for continued research. Much needs to be learned about the psychiatric illnesses that prevent older adults from living productive, enjoyable and independent lives. In spite of some recent changes, reimbursement for psychiatric services has lagged significantly, and patients like Mrs. A., in the example above, may not be able to afford to have a potentially treatable disorder treated.

Chairman STARK. Thank you, Dr. Billig.
Dr. Smyer.

STATEMENT OF MICHAEL A. SMYER, PH.D., PROFESSOR OF HUMAN DEVELOPMENT, PENNSYLVANIA STATE UNIVERSITY, UNIVERSITY PARK, PENNSYLVANIA

Mr. SMYER. Thank you, Mr. Chairman and members of the committee. My name is Michael Smyer. I am a clinical psychologist by training and am a licensed psychologist in the Commonwealth of Pennsylvania. I am a professor of human development and associate dean for research and graduate studies in the College of Health and Human Development at Penn State University.

And, Mr. Chairman, as you said, I have drawn the shortest straw and my testimony will be brief therefore. I really come to you drawing on 15 years of experience in both research on the effectiveness of mental health services for older adults and experience in the development and implementation of mental health and physical health problems for older adults and their families.

And I, too, have a book entitled, "Mental Health Consultation in Nursing Homes." And I really want to underscore many of the messages that my colleagues have already presented today. Basically I have three points to make for you and your colleagues, Mr. Chairman.

It is clear that there is a large unmet need for mental health services among older adults in the country today. Second, there is a wide-range of a variety of effective treatments including, but not limited to, pharmacotherapeutic approaches to problems of the older adults. And, third, our most effective treatment approaches and our most effective training approaches involve interdisciplinary collaborative approaches to older adults' mental health problems and in their interdisciplinary collaborative approaches it seems to me that the issue is not one of access, but one of involvement, appropriate involvement of appropriate disciplines as the need arises in a particular clinical case.

Our best treatment and our best training approaches are all geared toward what has come to be known in the field as seeking the least restrictive treatment approach. We can think of that term, "least restrictive," in a variety of ways: Least restrictive from a physical restriction perspective, least restrictive in terms of the use of chemotherapy or—I am sorry, pharmacotherapy, using the least amount of drug treatment as appropriate; least restrictive in terms of environment, finding the least restrictive environment to deal with Alzheimer's disease and other dementias.

And I would add, least restrictive from a regulatory perspective, to make sure that the appropriate collaborative involvement of the variety of disciplines, mental health and physical health can be brought to bear on older adults' mental health problems. Let me give you one short example of the way in which the system currently does not allow us to develop that least restrictive approach and then return to the nursing home setting as an example where some changes could occur that would improve the quality of care.

The example I draw upon comes from State college, Pennsylvania, the home of Penn State University. Penn State used to have a

football team and is also known as a place called the Happy Valley. It is a misnomer in many ways because Penn State, although a town of 35,000 is also the major mental health treatment setting for 13 counties in central Pennsylvania.

For almost a decade, I was the only mental health professional in that town with any type of geriatric training and expertise. My colleagues and I realized that there was a need for additional in-patient mental health services and together we developed a 92-bed free-standing mental health psychiatric facility with five specialty units, one of them focused on older adults and their treatment.

Because of my background and expertise, I was given the task of recruiting a geriatric psychiatrist to head up that specialty unit. I would have to say that my colleague is accurate in describing the development of geriatric psychiatry. It was a young field and I was unable to attract a geriatric psychiatrist to our setting in part because many of the people who are getting trained in the settings representing on this panel are now going into academic medicine or into private practice.

Fortunately, I was able to identify a geriatric psychologist who had more than a decade of research and clinical experience in program development and treatment of mental health problems with older adults and their families.

Unfortunately, I was told that he would not be appropriate for leadership role in geriatric treatment because of Medicare reimbursement issues. I will give you the punch line. We hired a psychiatrist who had no geriatric experience or interest. Within 6 months, the older unit was closed and converted to a specialty unit dealing with adolescent in-patient problems. Not surprisingly, the interest area of the psychiatrist we hired and the net effect was that the older adults in that 13-county area had no increase in in-patient mental health services available to them.

I give you this example because I think it represents the deadening effect of current regulatory limitations. The current restrictions reflect neither our best practice models have interdisciplinary team approaches nor the realities of relatively few mental health professionals with geriatric training.

In addition, the current regulatory climate does not reflect what we know about what works even with the most impaired populations in the most distressed settings such as nursing homes. We know that there have been treatment programs that have involved interdisciplinary approaches, programs such as those developed by Roger Patterson and his colleagues in Florida taking regressed mental hospital patients and nursing home patients and restoring them to more effective psycho-social functioning and decreasing the use of inappropriate medications.

These sorts of approaches have been tried. I would say Peter Rabins is right that the kind of research that is needed is not out in the field yet, but we do have case examples, Patterson's work was used as a model for a State-wide program in Florida for the treatment of older adults with mental health problems.

In summary, I think those of us who work in the field of geriatric mental health are very clear that the best treatment models and training models involve collaborative interdisciplinary approaches to the older adults and their families. Interdisciplinary

approaches that focus on the least restrictive, effective treatment approaches for the variety of mental health problems that older adults present to us either in the community setting or in nursing home settings.

Thank you.

[The statement of Mr. Smyer follows:]

Statement of Michael A. Smyer, Ph.D., Pennsylvania State University

Introduction

Mr. Chairman, Thank you for providing me this opportunity to testify today. My name is Michael Smyer. I am a clinical psychologist by training and a licensed psychologist in the Commonwealth of Pennsylvania. I currently work as a Professor of Human Development and Associate Dean for Research and Graduate Studies in the College of Health and Human Development at Pennsylvania State University.

I am a fellow of the American Psychological Association, and a fellow of the Gerontological Society of America. I have also been a W.K. Kellogg Foundation fellow and a fellow of the American Council on Education. For the last fifteen years I have been involved in research, education, and program development in the area of aging and mental health.

During the last ten years, I have focused on the development, implementation, and evaluation of health-related interventions for older adults and their families. During this time, I have been a founding board member of a 92-bed free-standing inpatient mental health facility, the Meadows Psychiatric Clinic in Centre Hall, Pa., and a founding board member of a continuing care retirement community that will serve 200 older adults, Foxdale Village in State College, Pa. In addition, I have pursued a program of research focusing on the mental health needs of a particular setting: nursing homes (See Smyer, Cohn, & Brannon, 1988).

Thus, I come before you today as both a researcher involved in evaluating effective treatment approaches for mentally ill elderly and as a practitioner involved in developing services for mentally and physically impaired elderly and their families.

I have three simple messages for you and your colleagues today. 1) There is substantial unmet need for mental health services among older adults; 2) Effective treatment approaches are available--even for those most impaired and even in the settings with the greatest need; and 3) Optimal treatment requires a collaborative, not a hierarchical, approach to care in which the elderly have direct access to both psychological and psychiatric expertise.

There are simply too few mental health practitioners available with extensive experience with older adults, therefore, older adults and their families should be encouraged to access the diverse service system through whatever mental health expertise is available in their local community.

A case example may help to illustrate the difficulties facing mentally impaired older adults and their families as they seek mental health services.

State College, Pennsylvania, the home of Penn State, is a good example. For almost a decade, I was the only mental health professional with geriatric training in a town of 35,000 townspeople and 35,000 students. Moreover, because of the university, State College provides mental health services for a broad area of central Pennsylvania. Thus, several counties rely upon our mental health practitioners and I was the only clinician with geriatric training.

Because of the need for inpatient facilities for treating mental disorders, I became involved in a project to develop a free-standing 92-bed mental health hospital. The original design called for an older adult specialty treatment unit--one of five units in the hospital. Because of my experience in the area, I was called upon to recruit the leadership for the geriatric unit. I was unable to locate a geriatric psychiatrist interested in a full-time treatment setting. My assessment was that the field of geriatric psychiatry is still relatively young--so that the majority of psychiatrists with geriatric training are taking

academic appointments upon graduation. Since that time, many colleagues have corroborated this impression.

Because of the shortage of specially trained psychiatrists, I felt fortunate to be able to recruit a well-trained psychologist with more than a decade of geriatric mental health experience. Both as a clinician and researcher, this colleague was a leader in geriatric treatment. Unfortunately, I was told that we could not hire him as the unit director, since Medicare coverage required a physician in the role.

I am saddened to tell you what happened: We hired a psychiatrist, with no geriatric training. He had no significant interest in serving older adults and their families, and no training in their concerns. Within six months of his arrival, the older care unit was closed and has been converted to an adolescent treatment unit--more in keeping with the training of the psychiatrist. Once again, a 13 county area of central Pennsylvania was without an inpatient treatment facility for mentally ill elderly.

Current federal policy on mental health care for the elderly reflects neither our best practice models of interdisciplinary team approaches nor the realities of relatively few mental health professionals with geriatric training.

The bottom line is that the elderly experience great difficulty accessing mental health services. Most older adults with mental health disorders do not have the luxury of choosing among several different professionals with a background in geriatrics. More often, they must rely upon the single practitioner who is most available whether that practitioner is a psychologist, physician or psychiatrist. The case of State College is not an isolated situation; there are many communities in which a sole provider is available for older adults and their families.

Need for Geriatric Mental Health Services

Recent reports from the NIHM-funded Epidemiologic Catchment Area studies (Regier et al., 1984) document two trends: approximately ten percent of older adults have a mental disorder; and cognitive impairment resulting from Alzheimer's disease or another dementia accounts for approximately half of the mental disorders of the elderly (Weissman et al., 1985; Regier et al., 1988). Despite these levels of impairment, however, older adults are under-represented in the case loads of traditional mental health settings (Gatz, Smyer, & Lawton, 1980). Instead, they are over-represented in other settings, such as nursing homes. Epidemiologic studies (e.g., German et al., 1986; Rovner et al., 1986) document that nursing homes have become a major receiving site for mentally ill elderly. Estimates vary, but perhaps as much as 94% of elderly residents in nursing homes have a mental disorder. In addition, many of these residents have behavioral disturbances (e.g., wandering, agitation, aggressive outbursts) that make the provision of care difficult. (See Smyer et al., 1988, for a summary of these issues.)

Thus, the need for mental health services for older adults is well-documented. What about the effectiveness of services?

Effective Treatment Approaches

During the last twenty years, there has been a significant improvement in our understanding and treatment of the mental disorders of older adults. Recent collections document the range of effective treatments and the important elements that contribute to effective assessment and treatment (see, for example Blazer, 1982; Burnside, 1978; Hussian & Davis, 1985; Knight, 1986; Poon, 1986; Teri & Lewinsohn, 1986; Wattis & Church, 1986). Since my comments today cannot be an exhaustive discussion of treatment issues, I want to highlight two patient groups for which effective assessment and treatment strategies

have been documented: Alzheimer's patients and the institutionalized elderly.

Approximately 5% of those over 65 suffer from severe cognitive impairment. The most common cause is Alzheimer's disease. By age 80, 15-20% of the elderly have significant cognitive impairment, with approximately half of those suffering from Alzheimer's disease which requires a coordinated effort of many professionals. In the diagnostic process, psychological behavioral assessments of memory, mood, and functioning are combined with typical physician tests to rule out other disorders. Unfortunately, no single diagnostic procedure is definitive, and instead the pattern of findings is of concern (Poon, 1986; Wattis & Church, 1986; Zarit, 1980). In this diagnostic process, psychologists, psychiatrists and other physicians collaborate with nurses and social workers to arrive at a comprehensive assessment. Restricting direct access to one provider group greatly reduces the possibility of rapid and effective diagnosis and treatment since it greatly reduces the likelihood that the elderly will seek care or that they will find a provider with appropriate diagnostic skills.

Once the diagnosis of Alzheimer's disease is designated, the emphasis shifts from "cure to care." (Cohen, 1987). As Fogel (1988) recently noted, the treatment of Alzheimer's disease requires a "combination of environmental, psychological, and medical interventions." Again, all four mental health disciplines contribute. Psychologists develop and implement behavioral strategies to maintain effective functioning. Primary care physicians monitor health concerns. Nurses provide care for the Alzheimer patient and the entire family. Social workers assist the family in a variety of transitions.

Alzheimer's patients and their families are best served by a variety of mental health providers. The same is true of institutionalized elderly. As noted earlier, nursing homes have become a major mental health (as well as physical health) treatment setting. Despite the significant rates of mental disorders in the setting, however, few psychiatrists provide treatment in nursing homes. Instead, the staffing pattern of nursing homes is a pyramid, with the base formed by nursing assistants. Therefore, we must not only improve the availability of mental health experts like psychologists, but also effective intervention approaches must focus on consultation and education strategies with primary medical care staff. The recent Institute of Medicine report (1986) and the recent Omnibus Budget Reconciliation Act of 1987 (OBRA) acknowledge the key role of staff interventions.

Work with disruptive, disoriented, and impaired residents has proven effective in maintaining and restoring competent functioning and eliminating severe behavioral problems of the sort documented by Rovner and his colleagues (Rovner et al., 1986). For example, psychologist Roger Patterson and his team of clinicians developed effective behavioral management strategies to return functioning to older adults who had been institutionalized for many years (Patterson et al., 1982). Patterson's work formed the foundation of a statewide program of assessment and treatment implemented in the state of Florida. Similar approaches have been used in nursing home settings by psychologist Richard Hussian and his colleagues (e.g., Hussian and Davis, 1985). (See Smyer et al, 1988, for a summary of effective intervention approaches with agitation, depression, and disorientation.)

The importance of Interdisciplinary Team Approaches

Effective treatment of the mental disorders of older adults requires first, improved availability of mental health experts like psychologists and second, collaboration among mental health experts with primary care providers. In order to be most responsive, the optimum service delivery system must be organized to allow the older adult and the family to access treatment

through any of the core professions. Older adults' patterns of seeking mental health assistance are clear: they usually do not seek help in traditional mental health settings from *psychiatrists*. Instead, they often seek assistance via other referral and treatment routes. Therefore, to be most responsive, Medicare-funded services must acknowledge the importance of unique contributions of mental health experts other than psychiatrists.

This concept--the importance of multi-disciplinary teams--is well-established in both education and practice in gerontology and geriatrics. At the most outstanding centers of geriatric training, with funding from the National Institute of Mental Health and the National Institute of Aging, a number of disciplines work together, complementing the contributions of each. At Duke University, for example, the Older Adults Resources and Services (OARS) clinic requires the input of psychiatry, psychology, nursing, and social work for the development of an effective treatment approach. The same is true at the Philadelphia Geriatric Center, a nationally renowned service setting. In summary, there is no doubt among geriatric professionals that interdisciplinary approaches are the most appropriate and most effective. Hierarchical delivery systems only reduce access to optimal care.

In summary, I want to end the way I began, with three simple messages for you and your colleagues today: 1) There is substantial unmet need for mental health services among older adults; 2) Effective treatment approaches are available--even for those most impaired and even in the settings with the greatest need; and 3) Optimal treatment requires a collaborative, not a hierarchican, approach to care in which the elderly have direct access to both psychological and psychiatric expertise.

Geriatric mental health expertise is not readily available in most local communities. To better serve older adults and their families, it is important tc assure access to mental health services through contact with mental health experts.

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Chairman STARK. I want to thank the panel. This is, as you know, a somewhat distant issue from what we were talking about previously relating to the two bills involved, but something that increasingly comes to our attention. We do not, as far as I know, have any legislation before us outside of the general issue of quality care in nursing homes, but it is an issue that we are hearing about increasingly, concerns for the care of elderly patients who are living in nursing homes or extended care facilities.

I think we will be calling on all of you in the future to think about what, if any, legislation we need to consider to address the problems that you raised today.

Mrs. Johnson.

Mrs. JOHNSON. I would like to know what your comments are in the new regulations that have just come out, is that a legitimate question, Mr. Chairman? Can we go into that? The new regulations that have just come out? The OBRA's, correct, you have testified Dr. Billig, as to—wait a minute, Dr. Beers, that you know there is a lot of concern with the use of drugs out there and I have read a number of other things that speak to that concern and the kinds of things that your testimony addressed.

On the other hand, in some of the other testimony, while Dr. Billig says that "depression and other mental or physical disorders are not parts of normal aging." He does go on to say, "in no other age group is the relationship between mind and body so striking."

When you see what nursing homes are faced with and uncles and aunts and parents go through this, our nursing homes are facing very, very difficult medical and behavioral problems in their patients. And I am concerned when I hear from the panel how little we know about what drugs work and how to better manage patients that we have adopted regulations that are requiring a level of decisionmaking about individual lives, that is going to be traumatic to many seniors in my district.

I am coming to this hearing from having met with my nursing home directors who are panicked and families who are telling me that even if they want to pay for the care, the Government's going to move their relatives out of the nursing home if the Government says that they aren't getting the least restrictive care.

Now, given the complexity between physical and behavior issues, our minimal knowledge about how to manage the cases, our lack of personnel who are skilled, failure to develop an interdisciplinary system that works, I view these new regulations with great distress and wonder if under them we are going to be able to act for the patient's benefit for now.

And in view of the variety of comments you have made, how do you think we ought to be proceeding? Should research be preceding these kinds of regulations, what portions of these regulations are we prepared to implement? What is your advice to us?

Dr. RABINS. I would like to comment, if I may. If you are referring to the nursing home screening legislation, I absolutely agree with you. I think it is travesty that was put in at the last minute with absolutely no forethought and the people unfortunately who will suffer are family members and individuals who do need this kind of care. So, I would fully share that, Mrs. Johnson.

Mr. SMYER. I think one thing that could be done now is to direct research in looking at what are the effects of those regulations. For example, what happens when people are screened out? Dr. Beers' work and other work by Jerry and his group suggest that in the rest home industry which is separate from the nursing home industry and even less regulated that we already have concerns about overmedication and inappropriate medication.

My concern is that many of the people who will be screened out of nursing homes will go into this other sector that is even less regulated. All because of well-intentioned efforts on the part of Congress to try to provide better quality of care, but right now we have no idea what will happen for those people when they get screened out and there is very little attention being given to that.

In Pennsylvania we have been working with the Department of Aging and Education which is implementing some of these regulations to put together just a very basic descriptive study of what is the natural history of outcomes for people who get screened in or screened out.

Right now, our level of knowledge is very basic and we don't even have that basic information.

Mrs. JOHNSON. Are you aware or can you tell me in this screening process will it allow people to stay in nursing homes that are receiving a reasonable drug program? Is it trying to differentiate between those receiving reasonable and unreasonable drugs and on what basis are they making that decision?

Dr. RABINS. Each State is left to its own devices. In Maryland——

Mrs. JOHNSON. But each State is having a terrible time.

Dr. RABINS. Right. At least in Maryland, the fact that you either have a psychiatric diagnosis and that does exclude Alzheimer's disease in the legislation, but let's say you were depressed. You had a stroke and you were depressed. You would need to be screened or if you were taking a psychoactive drug, you would need to be screened. Beyond that, the regulations at least in Maryland don't necessarily proscribe that the person be removed from the home.

They just proscribe that something be done in some vague way. My own personal concern is having had some contact with HCFA, that their approach is that this is a way to keep people out of nursing homes and that is their single minded purpose.

I do not think that that was the intent of Congress, not that I would really know, but that doesn't seem to me to be the purpose. The purpose was to improve care and I think if there were some way to direct HCFA to this issue, whether through research or prescribing improvement of care, I think at least we carry out the will of the Congress.

Right now their ideas will cut down the number of people in homes and I think very few people go into nursing homes who don't need that treatment. Most families in my experience in fact probably wait too long, if there is a mistake made. So what we need to do is focusing on making it better, but getting the people who don't need that kind of treatment out.

Mrs. JOHNSON. I saw my red light flick on so I won't pursue this. But, and also I think it is really almost too big a topic for us to deal with in this kind of a format, but I would be very interested in

getting a better handle on what requirements you think we could, and this goes not just for this panel, but for anyone who is here today, know what we could be requiring of Government in terms of research and oversight of this process and also if there are any small aspects of the regulations that we ought to be fighting to change.

I certainly will be watching it through my families and through my very distressed and I might say overburdened nursing home administrators and personnel. So I think that this is a very hot and difficult subject and I would be happy to meet with any of you.

Mr. SMYER. If I could follow up, we talked about the screening regulations, there is a whole set of regulations, as you know, that relate to nurses aid training. Those, too, have some implications for the nursing home industry in the ability to attract and retain workers which is a pressing need for that industry.

I think that the regulatory body hasn't thought that through, nor given sufficient attention to the mental health needs. Some work that our group has been doing suggests that you can't just impose the training regulations without also looking at some of the organizational factors that effect the willingness and the ability of the workers to take part in the training.

Mrs. JOHNSON. The relationship between medical and physical symptoms in older years, certainly to have training that isn't specifically geared to this is a problem. Thank you.

Thank you, Mr. Chairman.

Chairman STARK. Thank you. Mr. Moody?

Mr. MOODY. It has certainly been sobering testimony. And you have certainly spoken articulately on the possible unintended side effects of the O'Brady Seven requirements. I wonder if the four of you or any subset of you would be willing to write those comments down?

We would be interested in reading that, having that in a more formalized way. And that applies to previous panelists, too. It has been an interesting session, to say the least. What you four and some of the others have presented has been a very disturbing picture of the inadequacy of mental health care for senior citizens, particularly in nursing homes, but not only in nursing homes.

In that vein, do the four of you generally support the thrust of this bill? I don't think any of you spent too much of your testimony actually focusing on the bill so much as setting the stage as to what some of the problems are.

Is it fair to say that you do support this approach, given what you have just said or am I jumping to a false conclusion? Do you want to do it in turn? Any other?

Dr. BEERS. From an internist's point of view, I agree we need more mental health care in nursing homes. I have to ask myself: How is that best supplied?

Mr. MOODY. Given budget constraints.

Dr. BEERS. Yes.

The majority of care in nursing homes is given by nurses. Until we have nurses who are with patients 24 hours a day who are equipped to help our patients, I don't think we will make good inroads in helping them through psychological illness that does not require drugs.

When it comes to the use of drugs, I have to ask myself whether the psychologist will be helpful. The psychiatrist or better trained internist knows more how to use those drugs.

Mr. MOODY. At least with psychologists we won't be seeing overapplication of drugs, since they are not authorized to prescribe any.

Dr. BEERS. That is true. But that currently exists even though there is minimal psychiatric or psychological work in nursing homes.

The nurse practitioners working in nursing homes have prescribed these medications, even though they don't have the training to do it.

Mr. MOODY. Supplementing psychologists, making it more accessible through Medicare, you are not sure it will improve the situation at all?

Dr. BEERS. That is my concern. We are testing to see whether pharmacists or others can do it. I am trying to look at systems approaches, in-house regulations. But how to do it, we don't have the answer yet.

I think we should find out the answer if we are thinking about passing a bill.

Mr. MOODY. Dr. Rabins.

Dr. RABINS. Any way we can improve the health care of nursing homes. If we can make it possible to have psychologists to practice in them, I would strongly support it.

I think we need trained professionals now. It is collaboration. The problem is not that one specialty is better than another; I think the issue now is that no single specialty—pharmacists or psychiatrists—at this time is able to provide enough care. So I strong support some form of this.

Dr. BEERS. I am for allowing psychologists to practice in nursing homes but I think their impact on the medications may be minimal.

Dr. BILLIG. I generally agree with Dr. Rabins. I am very disturbed about the implications of having nonmedical people fully involved with the very ill and very frail nursing home patients and outpatients we see. Not a day goes by that I don't use my medical training and new geriatric training that I have had in the last 10 years to deal with the complex interaction.

I advise internists and family practitioners what thyroid tests need to be done and other tests, because I have gotten to know what the mix of physical, geriatric and emotional problems is.

There is no disorder that we treat without a diagnosis. That is essential. That is how the progression goes in terms of deciding what to do.

Mr. MOODY. One could argue that your mix of skills is really what we need. But since there are very few of you relative to the need, the question is what constraint do we use in order to address the problem? This is one constraint we might be easing.

The question is not that your training is not right on target, but that we don't have enough people with that mix, whatever mix of schools could be used.

Dr. BILLIG. I would make a side pitch for more people like me, Dr. Rabins and the other people on this panel.

Mr. SMYER. I would support the bill and make these observations. We are talking about diagnosis as if it were a discrete event. But diagnosis is a process. We would want continued involvement of a variety of disciplines, medicines, psychiatry, psychology, whether the G.P. or a psychologist or psychiatrist.

Mr. MOODY. Do you see this bill as helping or not?

Mr. SMYER. Yes, I do. In some areas where there is limited geriatric expertise, we want to make that access available. This bill could help.

Even in the nursing home setting, even with very regressed patients, a variety of disciplines, including psychology, would be effective in dealing with all the behavioral problems. We know that psychological approaches can be effective with very regressed patients which can improve the quality of life for the patients and the situation in the nursing home.

Mr. MOODY. If the psychologist is intervening in a very helpful way, it may prepare the patient to be more receptive to medical approaches that may also be indicated?

Mr. SMYER. It could.

Mr. MOODY. It is not necessarily a conflict?

Mr. SMYER. Anything we can do to get more appropriate mental health expertise into nursing homes, I am for it.

Mr. MOODY. One gentleman says it has to do with the pharmacological issues he has been raising.

Dr. BEERS. We also have doctors practicing in nursing homes that don't know geriatrics. How will we be sure that the psychiatrists and psychologists practicing on the elderly have the special training? I hope when you write this bill, you will deal with this question.

Mr. MOODY. It would be hard to include that in the bill. Presumably they would be motivated.

Chairman STARK. Thank you very much for your participation today.

The committee will stand in recess.

[Whereupon, at 4:40 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

STATEMENT BY

DR. MARK R. GINSBERG, EXECUTIVE DIRECTOR

OF THE

AMERICAN ASSOCIATION FOR MARRIAGE AND FAMILY THERAPY

BEFORE THE HOUSE WAYS AND MEANS COMMITTEE

SUBCOMMITTEE ON HEALTH

REGARDING

ISSUES RELATED TO THE COVERAGE OF PSYCHOLOGISTS' SERVICES

UNDER THE MEDICARE PROGRAM, INCLUDING H.R. 774

March 23, 1989

Mr. Chairman, on behalf of the American Association for Marriage and Family Therapy (AAMFT), I would like to commend you for holding hearings on the important issue of the provision of mental health services by appropriately designated, authorized and eligible mental health professionals under the Medicare Program.

I ask that my statement be included as a part of the printed record being prepared for the hearing on this topic which was held on March 6, 1989.

AAMFT is supportive of efforts to review both the question of the provision of mental health services under Medicare and the important matter of determining which mental health professionals should be authorized and eligible under federal law to provide such mental health services.

As you have pointed out in your opening statement immediately prior to the March 6, 1989, hearing on the subject, "What Medicare beneficiaries with mental disorders need is a team approach to mental health professionals who are well trained, concerned and dedicated to the care of their patients."

Indeed, the question of determining which mental health professionals should be eligible to provide mental health services under the Medicare program is, as Senator John D. Rockefeller IV stressed in his testimony before your Subcommittee on the issue on March 6, 1989, "a beneficiary issue." The central and essential issue that must be addressed is the question of access to care. It is incumbent upon the federal government, in the view of the AAMFT, to be certain that mental health services under Medicare be provided by well trained providers to whom beneficiaries have free and easy access. This best can be accomplished by developing standards and criteria for determining which mental health professionals should be authorized and eligible to provide mental health services under Medicare.

As several witnesses have pointed out in their oral testimony: 1) the elderly both receive less mental health care than they reasonably (by any standard) can be expected to need, and 2) one important reason for this is that without ready access to qualified mental health professionals, their ability to obtain mental health care is unnecessarily restricted.

AAMFT is in a unique position to provide expert commentary on this important issue before your Subcommittee - the matter of allowing access by Medicare beneficiaries to well trained and appropriately credentialed mental health professionals.

As an organization with a membership comprised of virtually all of the mental health professions - including physicians, psychologists, marriage and family therapists, social workers, psychiatric nurses, and clergy - AAMFT can address this issue without professional bias or one-dimensional professional self-interest.

AAMFT's RECOMMENDATION

AAMFT recommends that as the Congress considers the question of adding "psychologists" as authorized and eligible providers under Medicare, that the question itself must be broadened.

AAMFT recommends that the question addressed not exclusively be whether psychologists should be included as authorized and eligible Medicare providers - to which we do not object - but rather what standards and criteria should be established by the federal government to identify and define - with due respect for the underlying and overriding issues of beneficiary access and quality of care - which mental health professionals should be authorized and eligible to provide mental health services under Medicare.

AAMFT believes limiting the consideration of this issue to a review of the possible inclusion within Medicare of psychologists is not consistent with the principles of effective public policy development.

Alternatively, AAMFT recommends that the question be recast within a broader context, and that the deliberation focus not exclusively on the matter of adding psychologists to Medicare, but that the fundamental premise of the debate must be to review more comprehensively the subject of mental health professionals' inclusion within Medicare.

Specifically, AAMFT recommends that the discussion focus on the development of standards and criteria defining a mechanism to determine which mental health professionals should be authorized and eligible to provide mental health services independently within Medicare - including both psychologists and other mental health professionals. We believe that the consideration of authorized and eligible mental health professionals under Medicare must include those mental health professionals with specific academic training and supervised clinical experiences in the profession of marriage and family therapy.

A DESCRIPTION OF AAMFT

The American Association for Marriage and Family Therapy (AAMFT) is the national professional association of qualified practitioners of marriage and family therapy. Founded in 1942, AAMFT has over 15,000 members nationwide and divisions in almost every state. For more than 45 years, AAMFT has been involved with the problems, needs and changing patterns of marital and family relationships. The Association works to increase understanding, research and education in the discipline of marriage and family therapy, and to ensure that public needs for necessary marriage and family therapy services are met by appropriately and well-trained practitioners. In addition, we have a close working relationship with the California Association of Marriage and Family Therapists (CAMFT) which represents the interests of the more than 17,000 licensed practitioners of marriage and family therapy in the state of California.

As the leading professional organization in the field, AAMFT has been at the forefront in promoting the education and training of marriage and family therapists. In 1978, AAMFT's Commission on Accreditation for Marriage and Family Therapy Education was designated by the then U.S. Department of Health, Education and Welfare as the sole national accrediting agency for graduate degree and post-degree training programs in the field. The U.S. Department of Education has renewed the Commission's designation three times, most recently in 1985.

AAMFT is also at the forefront in promoting the education and training of marriage and family therapists by advocating for state regulatory laws to license or certify marriage and family therapists. At present, 18 states license or certify marriage and family therapists: California; Arizona; Colorado; Connecticut; Florida; Georgia; Massachusetts; Michigan; Minnesota; Nevada; New Jersey; North Carolina; Rhode Island; South Carolina; Tennessee; Utah; Washington and Wyoming. Approximately 20 state legislatures currently are considering bills which, if enacted, would regulate the profession of marriage and family therapy.

Development of the Profession of Marriage and Family Therapy

Marriage and family therapy means the diagnosis and treatment of mental and nervous disorders within the context of marital and family systems. The practice of marriage and family therapy involves the application of psychotherapeutic and family systems theories and techniques in the delivery of services to individuals, couples, and families for the purpose of treating such diagnosed mental and nervous disorders.

The development and widespread acceptance among researchers and clinicians of marriage and family therapy as a critical modality for intervening with an array of mental and nervous disorders has helped to foster the rapid evolution of the practice and profession of marriage and family therapy. Mental health treatments applying the systemic principles of marriage and family therapy already are interventions included by relevant procedure codes within th Medicare program. That is, this service is an authorized service within Medicare, even though those mental health professionals most well trained to provide these services - mental health professionals specifically trained in the discipline of marriage and family therapy - are not currently authorized or eligible to provide services independently within the Medicare program.

Direct Recognition of Qualified Marriage and Family Therapists and Other Mental Health Professionals Will Enhance the Quality of Health Care and is Cost-Effective

AAMFT believes that a broad-based, direct recognition of qualified marriage and family therapists and other mental health professionals within Medicare will be a cost-effective means by which to ensure broad consumer access to necessary and high quality health and mental health services. Furthermore, it helps to ensure that beneficiaries can choose from a range of qualified providers in order to meet their health and mental health service needs. Such a provision is particularly important for allowing greater access to necessary mental health services in underserved and rural areas.

Marriage and family therapists increasingly are included in major national, regional and local health benefit reimbursement programs. For example, since 1966 marriage and family therapists have been reimbursed by the Civilian Health and Medical Plan for the Uniformed Services (CHAMPUS). During the 100th Congress, marriage and family therapists were viewed as authorized and eligible providers under provisions of the historic "Minimum Health Benefits for all Workers Act" (S-1265), legislation colloquially often referred to as the "Kennedy-Waxman" legislation.

In 1988, the Congress also recognized marriage and family therapy as a core mental health profession within the provisions of the Public Health Service Act. As such, accredited university-based graduate training programs in marriage and family therapy (as defined above) are eligible to apply for federal clinical training funds administered by the National Institute of Mental Health (NIMH).

Another indicator of the growing trend toward direct recognition of marriage and family therapists is that the Congress is presently considering adding marriage and family therapists to the Federal Employees Health Benefits Program (FEHBP), our nation's largest group health insurance program (H.R.211). An identical bill was passed by the full House of Representatives near the conclusion of the 1986 congressional session (H.R. 4825), but was not considered by the Senate. The situation and array of issues relevant to Federal Employees Health Benefits Program legislation are directly applicable to the debate regarding direct recognition within Medicare.

AAMFT believes that direct recognition for qualified marriage and family therapists would allow wider access by Medicare beneficiaries to needed services. Such reimbursement also would help to curtail the spiraling costs of health care. Indeed, when necessary services are delivered by appropriate providers -- including marriage and family therapists -- both proper treatment and cost-savings result. Certainly, this is in the public interest.

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AAMFT's Recommendations Regarding Direct Recognition Language
for Marriage and Family Therapists

Clearly, in our view, a broadened direct recognition provision, not limited to psychologists - and including marriage and family therapists and other qualified mental health professionals - is an amendment necessary to improve H.R. 774.

AAMFT believes that state licensing or certification laws should be used as one method to determine which marriage and family therapists should be determined to be eligible and authorized for participation within Medicare. That is, in those states which license or certify marriage and family therapists, these providers should be eligible for direct reimbursement under Medicare if they are licensed or certified by the state.

However, in our view, it would be a serious mistake for the Congress to prohibit direct recognition of qualified providers residing in states which do not, as yet, license or certify a particular mental health profession, such as marriage and family therapy. In states where there is no regulation at the present time, there are recognized alternative methods of establishing the qualifications of mental health providers. For example, currently in several different sections of federal law the services of clinical social workers are recognized specifically when a clinical social worker resides in a state which does not license or certify the profession of clinical social work, but when such an individual is recognized by an appropriate national credentialing organization.

A similar system exists for determining qualified professionals in the marriage and family therapy profession. AAMFT administers a careful system for evaluating applicants seeking the status of "Clinical Member" of the Association. The standards for obtaining AAMFT Clinical Membership are equally as rigorous as are the requirements for state licensure or certification. In order to become a Clinical Member of AAMFT, a mental health professional must complete a master's or doctoral degree in marriage and family therapy, or an equivalent course of study and degree. Following receipt of a qualifying degree, completion of two calendar years of work experience in marriage and family therapy under appropriate supervision also is required. This clinical experience involves successful completion of at least 1,000 hours of direct clinical contact with couples and families, and 200 hours of direct supervision of that work -- at least 100 hours of which must be in individual supervision.

To limit direct recognition of marriage and family therapists to those practicing in states which currently license or certify the profession will discriminate unfairly against thousands of Medicare beneficiaries. One of the major reasons for requiring direct recognition of qualified non-physician mental health care providers is to provide access to such services in remote, rural, and other underserved areas of the country, where there is a clear shortage of mental health professionals. Many of those states do not currently license or certify marriage and family therapists.

AAMFT is committed to the enactment of stringent licensure and certification laws in all states. However, state legislatures increasingly are reluctant to venture into the field of professional regulation. As such, the passage of state laws is far more difficult today than even ten or fifteen years ago. Accordingly, to limit direct reimbursement of qualified mental health professionals to those living in states which currently license or certify such professionals, would, we believe, defeat the purpose of ensuring Medicare beneficiaries ready access to services.

Definition of a Qualified Marriage and Family Therapist

Mr. Chairman, we urge that you, and your colleagues, amend H.R. 774 to require that in addition to recognizing 'psychologists' as authorized and eligible Medicare providers, that marriage and family therapists and other qualified mental health professionals also be identified specifically as authorized and eligible independent providers under Medicare.

We recommend that H.R. 774 be amended to contain the following definition of a marriage and family therapist:

An authorized and eligible "marriage and family therapist" shall be an individual who:

1) possesses a minimum of a masters degree; and

2) has completed not less than two years of supervised clinical experience; and

3)(A) is licensed or certified by a State regulatory agency as a "marriage and family therapist," "marriage, family and child counselor," or under a similar title, so long as the State regulatory agency specifically licenses or certifies such providers; OR

(B) in the case of an individual in a State which does not provide for licensure or certification is eligible for Clinical Membership in the American Association for Marriage and Family Therapy.

AAMFT's Conclusion and Recommendation

AAMFT believes that the time has come for the Congress to consider carefully and comprehensively the important issues of identifying and defining authorized and eligible independent providers of mental health services under the Medicare program.

Although we are not opposed to the addition of psychologists as a specific class of authorized and eligible Medicare providers, it is our belief that the inclusion of psychologists within Medicare, without a thorough concomitant review of the inclusion of other mental health professionals as prospective authorized and eligible Medicare independent providers, is an inefficient and far too narrow approach to public policy development.

Alternatively, AAMFT believes and strongly recommends, that as the debate regarding this important issue continues, that the issues considered be extended to include a review and deliberation regarding the critical underlying question of identifying and defining criteria for a broadened spectrum of mental health professionals that are well trained and prepared to provide necessary and appropriate mental health services under the Medicare program. AAMFT strongly urges your Subcommittee to amend H.R. 774 by extending direct recognition to marriage and family therapists by including this important and respected group of mental health professionals as authorized and eligible independent providers under the Medicare program.

Mr. Chairman, on behalf of the more than 15,000 members of the American Association for Marriage and Family Therapy, I thank you for your efforts to review and enhance the Medicare program. We also thank you for your consideration of the issues we have raised and look forward to working with you and your staff regarding these issues and other critical issues concerning our nation's health policy.

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March 28, 1989

The Honorable Fortney Pete Stark
Chairman
Subcommitee on Health
Committee on Ways and Means
U.S. House of Representatives
1125 Longworth House Office Building
Washington, D.C. 20515

RE: H.R. 774--Medicare Coverage
of Psychologists' Services

Dear Chairman Stark:

The Health Subcommittee of the Ways and Means Committee recently held a hearing on H.R. 774, a proposal to authorize broad Medicare coverage of psychologists' services. The AMA would like to take this opportunity to inform you and other Members of the Ways and Means Committee of our opposition to this legislation.

The American Medical Association remains concerned over the inadequate level of coverage for mental health care under Medicare. The limitation in coverage for outpatient psychiatric care works a severe injustice upon Medicare beneficiaries who need and could benefit from this valuable care. However, we do not believe that the answer to the problem of unmet mental health care needs of the elderly and disabled lies in expanding access to psychologists.

As a starting point, the Medicare population needs better overall coverage for mental health care and the reality is psychiatrists and not psychologists treat the most ill patients. By opening the coverage door to other licensed mental health care practitioners, beneficiaries who could benefit from a medical regimen might find this essential care to be unavailable. Also, at a time of very limited resources, H.R. 774 inevitably will lead to a substantial increase in resources going to beneficiaries without an established medical need for mental health treatment.

While we do not support expansion of Medicare coverage to include further psychologist services, we are concerned that such expansion would authorize coverage of psychologists' services without a precondition that a medical differential diagnosis plan be completed that would allow a psychiatrist to certify that the beneficiary's illness is not organic in nature. Without such a guarantee, there would be no assurance that the care provided would be appropriate to the patients' conditions.

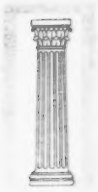
Finally, we believe that the area for reform of Medicare coverage for mental health care is the special limitation under Medicare that applies to payment for outpatient mental health care. If any federal resources are available, we urge the Committee to first apply these resources to increase the cap on the outpatient mental health services benefit. Also, we believe that the co-payment for mental health services for beneficiaries should be calculated in the same manner as for other physician services.

Sincerely,

James H. Sammons MD

James H. Sammons, MD

JHS/mjz



NATIONAL COMMITTEE TO PRESERVE
SOCIAL SECURITY AND MEDICARE

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I am James Roosevelt, Chairman of the National Committee to Preserve Social Security and Medicare. In that capacity, I represent more than five and a half million members and supporters most of whom depend on Medicare for their health care coverage. I commend the Chairman for holding hearings on access to mental health care for seniors - an issue that deserves immediate attention because seniors are being over-medicated at an alarming rate. Part of this problem is due to lack of available alternative treatment such as psychotherapy.

Mental health care for seniors has a low priority in our society, which is reflected in the fact that Medicare outlays for mental health services are a fraction of one percent. Medicare reimbursement for out-patient mental health services is more limited than reimbursement for other health care. Access to mental health services is limited because Medicare recognizes only psychiatrists as qualified to treat seniors -- in most settings. Some of the problem also lies with seniors themselves and their physicians, many of whom do not believe that a good talk with a mental health expert can be more effective than a prescription.

The National Committee supports legislation to provide Medicare coverage for psychology services. While this provision will not solve all the serious problem of over-drugging of seniors, it is an important first step towards improving access to mental health care for seniors. H.R. 774 and the Senate companion, S. 100, allows coverage of psychology services only when psychologists accept Medicare "assignment," -- a provision which we applaud.

There is ample evidence that seniors living at home as well as those living in institutions are being prescribed drugs that affect their minds, psychoactive drugs, at a much higher rate than the rest of the population. This problem is exacerbated by the fact that seniors commonly take many different drugs and they are more susceptible to adverse drug reactions than younger people because their bodies react differently to drugs.

The Inspector General's recent report on drug utilization by seniors found that two million seniors are addicted, or at risk of addiction, to minor tranquilizers or sleeping pills because of using them daily for at least one year. In 1985, an estimated 243,000 seniors were hospitalized due to an adverse drug reaction; 32,000 seniors incur hip fractures due to drug-induced falls every year and 163,000 seniors experienced serious mental impairment either caused or worsened by drugs. One of the four main reasons cited by the Inspector General for these problems is that the drug was unnecessary because the patient's condition was misdiagnosed or because nondrug therapy could be substituted.

Seniors have at least as many mental health problems as younger people, yet they rarely receive counseling by a mental health expert. In addition to life-long unaddressed problems, aging itself requires mental adjustment. The loss of loved ones, the loss of good health, the serious illness of a spouse, the transition from work to retirement are just a few of the issues that face many seniors. Such problems can lead to depression and feelings of hopelessness and helplessness. Some seniors seek out-side help to

deal with such problems - yet that outside help is often in the form tranquilizers, sleeping pills or other psychoactive drugs. Physicians, when at a loss for what to do, often prescribe a drug to help their patients and to make the trip to the doctor worthwhile. According to the National Institute on Drug Abuse, many physicians think of the senior's psychological problems as "natural" or "just part of getting old," and also have misconceptions about psychotherapy. NIDA concludes that this often leads to drug intervention when non-drug therapy would be more appropriate. Perhaps with the availability of more affordable psychological services and with increased education, physicians would be more likely to make referrals instead of prescribing a psychoactive drug.

As early as the mid-seventies, it was found that drugs were routinely used in nursing homes in an effort to calm down unruly residents and help them "adjust" to the institutional setting. Sadly, recent studies show that this is still widely practiced. Having more mental health experts available for consultation and assistance with depressed and "unsettled" residents would help cut down on potentially damaging drug use.

Medicare is the only major health insurance program which does not reimburse psychologists. Current law allows Medicare coverage of psychologists in community mental health centers and rural health clinics. If psychologists are considered qualified to practice under Medicare in those settings, they can surely do the job in all settings. Medicare coverage of psychology services will not increase costs significantly. CBO estimates that it will cost only $95 million over five years.

Allowing psychology services to be covered by Medicare in all settings would begin to reverse our society's low priority of mental health care for seniors.

STATEMENT OF THE NATIONAL FEDERATION OF SOCIETIES FOR
CLINICAL SOCIAL WORK, INC., AND
THE NATIONAL ASSOCIATION OF SOCIAL WORKERS

The National Association of Social Workers (NASW) and the National Federation of Societies for Clinical Social Work (NFSCSW) are very pleased to present their joint views regarding H.R. 774, legislation to expand coverage of psychologists' services under Medicare. NFSCSW is a federation of state organizations whose members are all clinical social workers involved in health and mental health practice; NASW is a membership organization representing over 120,000 professional social workers.

The social work profession has an historical track record of providing high quality health and mental health care. Massachusetts General Hospital hired its first medical social worker at the turn of the century. Since that time, social workers have become involved in virtually every component of the nation's health care delivery system, performing such critical functions as health education and promotion, high-risk screening and assessment, case management, financial counseling, patient advocacy, family education, discharge planning, post-hospitalization care and follow-through. And, today, clinical social workers are the single largest body of professionals offering mental health services to individuals, groups and families through private practice, group practice settings, health maintenance organizations, hospitals, agencies, clinics and employee assistance programs.

NASW and NFSCSW fully support coverage of psychologists' services through the Medicare program, but our concern with H.R. 774 is that the bill does not go far enough in extending Medicare beneficiaries' freedom to select their provider of choice among a range of duly regulated and qualified mental health care professionals, including clinical social workers. NASW and NFSCSW consider consumer freedom of choice to be a prerequisite to quality and cost effective mental health care.

UNMET MENTAL HEALTH NEEDS OF THE ELDERLY

It has been well documented in recent years that our health care delivery system has failed to meet the mental health needs of many of the nation's elderly population. Several years ago, the President's Commission on Mental Health conducted an analysis of governmental policy in the area of mental health service delivery, with particular focus on underserved populations. Many older Americans were found to have a greater need for mental health services than the general population (up to 25% of older persons are estimated to have significant mental health problems.)[1] Moreover, the Commission found that the elderly have insufficient access to services or to personnel trained to respond to the special needs of the elderly.[2]

Since then, other studies and reports have confirmed the findings of the President's Commission. According to a recent report by the Chairman of the House Select Committee on Aging, an estimated seven million of our nation's 28 million elderly population may currently need professional mental health treatment; yet very few of these persons are obtaining the services they need.[3] The report also notes that, although elderly persons represent about 12 percent of the general population, they only represent about six percent of those served by Community Mental Health Centers, and about two percent of persons served by private therapists.[4] The United States General Accounting Office recently released a report which also found that the elderly do not have adequate access to mental health services.[5] Finally, a 1984 study by the United States Department of Health and Human Services determined that less than four percent of psychiatrists' visits are provided to persons over age 65, even though this age group accounts for almost 20 percent of office visits generally.[6] Further, the study documents the fact that four out of five persons age 65 or older with a mental illness are seen by non-psychiatrist physicians.[7]

MEDICARE'S RESTRICTIVE REIMBURSEMENT POLICY

The Subcommittee's leadership in obtaining the recent increase in the Medicare outpatient mental health benefit is laudable. The previous $250 yearly benefit level was severely outdated, and while still limited, tne new $1,100 benefit level is a significant improvement. Benefit levels in themselves, however, do not ensure access to care. Medicare's improved outpatient benefit level has not succeeded in making mental health services available to a large segment of the Medicare population because it was not coupled with freedom of choice among qualified providers. The mental health delivery system in the United States has grown up over the years around the availability of a number of qualified mental health professionals, without regard to the discipline of the provider, yet Medicare currently will only pay for services rendered by a physician. The law does not even require that the services be performed by a trained mental health professional -- any physician will do. In this respect, the 20-year old Medicare program is out of step with the realities of today's mental health delivery system, which is universally recognized to consist of four "core disciplines" -- psychiatry, psychology, clinical social work, and psychiatric nursing. Consequently, many of the nation's elderly are often denied the freedom to select from a range of qualified providers simply because the therapist of their choice may be a clinical social worker and is excluded from the Medicare financing structure.

CONSUMER FREEDOM OF CHOICE WITHIN MENTAL HEALTH CARE

There are several compelling reasons why it is critical to extend Medicare coverage to services provided by clinical social workers and all other qualified mental health professionals. First, freedom of choice alleviates the problem of insufficient access to mental health care, particularly among underserved populations. Second, expansion of the pool of qualified mental health providers encourages healthy competition, enhancing cost-containment. And finally, increased utilization of mental health treatment has been shown to result in decreased utilization of more costly medical and hospital services.

The ability of a consumer to select from a range of qualified mental health care providers for reimbursable care can determine access to mental health care -- particularly in rural areas. The National Center for Social Policy and Practice's Preliminary Report of the Geographic Distribution of Mental Health Providers demonstrates this point. In its pilot study of the relative distribution of social workers, psychologists and psychiatrists in six states with large rural areas -- Illinois, Oklahoma, Michigan, Texas, Florida and West Virginia -- the Center found that:

- Social workers are the only licensed mental health providers in approximately 1/3 of the counties in five of the six states studied; and

- The counties in which social workers were the only available licensed mental health providers were more rural and poorer than neighboring counties, with average per capita incomes approximately 25% below the states' average per capita income.[8]

Inadequate access to mental health services and to trained mental health professionals led the President's Commission on Mental Health in 1978 to recommend that Medicare and other publicly financed mental health service programs should provide direct reimbursement to all independent qualified mental health professionals who meet the requisite standards of education, experience and professional licensure/certification.[9] The fundamental point made by the Commission was that federal financing mechanisms should be based upon the appropriateness of care, not the discipline of the provider.[10]

Insufficient access to mental health services is not the sole justification for urging consumer freedom of choice in selecting among qualified providers. Several years ago, a well-known health care consulting firm published the results of a study prepared for the Federal Trade Commission on competition among health care practitioners, which examined the influence of the medical profession on the health manpower market. The study concluded that one of the principal ways to broaden consumer choice, and to diminish the monopoly power of physicians, was to allow consumers the freedom to select among a variety of health professionals. "If carefully designed, a system based on broadened choice could preserve professional competency while increasing competition among providers on the basis of the service they provide, quality and price.[11] The study warned that "unreasonable resistance to change in present manpower arrangements has, in some cases, prevented appropriate utilization of health resources and possibly raised the cost of care."[12]

Lastly, some opponents of freedom of choice have argued that expanding the available provider base will cause a significant increase in utilization, and additional cost. Even if utilization were to increase with the inclusion of clinical social workers and other qualified mental health professionals in the provider pool, overall plan costs would not necessarily increase proportionately. To the contrary, the evidence strongly suggests that increased utilization would be offset by corresponding cost savings. For example, the President's Commission on Mental Health in 1978 concluded that increased utilization of mental health services yields decreased utilization of (more expensive) doctors, hospitals and surgery. "As a group, this research is most striking," the Commission reported. "Research from health maintenance organizations (HMOs), from industrial programs, and from regular health insurance plans suggests that providing outpatient mental health services can reduce overall health services utilization and overall health costs."[13]

The Commission also determined that as many as 60 percent or more of physician visits are from sufferers of emotional distress rather than diagnosable physical illness.[14] A similar finding was reported by the Department of Health and Human Services in its 1984 study report titled, "The Hidden Mental Health Network."[15]

An article published by the Alcohol, Drug Abuse and Mental Health Administration summarized the results of 12 separate studies which demonstrated that the cost of providing expanded mental health services was offset by a significant decline in medical utilization.[16]

Yet another study relating to the offset effect of mental health treatment on medical costs is a 1983 study on outpatient mental health treatment following the onset of a chronic disease. The findings indicate that outpatient psychotherapy beginning within one year of the diagnosis of one of four chronic diseases is associated with reduced charges for medical services by the third year following the diagnosis.[17] The authors conclude that the study "adds weight to the conclusion drawn from the reviews of the scientific literature that the inclusion of outpatient psychotherapy in medical care systems can improve the quality and appropriateness of care and also lower costs of providing it."[18]

THE CHAMPUS AND FEHBP EXPERIENCE

Federally funded health insurance programs such as the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) and the Federal Employees Health Benefits Program (FEHBP) have already recognized the importance of utilizing services of clinical social workers and other qualified non-physician mental health professionals. A 1986 study conducted by the Office of Personnel Management examined the effects of providing direct reimbursement to clinical social workers and other non-

physician providers under FEHBP. OPM concluded there was no basis to anticipate adverse impact on cost or quality of care from mandating coverage of qualified non-physician providers, including clinical social workers.[19]

The CHAMPUS program reports a similar experience. In 1980 Congress directed CHAMPUS to conduct a demonstration project by including clinical social workers as independent providers of covered services for a two-year period, in order to assess the impact on cost and utilization. In 1982, following this experimental period, Congress authorized continuation of the independent provider status based on the finding from the demonstration project that "no quality of care problems have arisen, and reimbursement of clinical social workers costs less than the traditional physician gate-keeper approach."[20]

CONCLUSION

NASW and NFSCSW would strongly recommend that the Subcommittee broaden the scope of Medicare coverage along the lines of H.R. 111, pending before the Committee. H.R. 111, the Mental Health and Aging Act, proposes a variety of reforms within Medicare and other federal statutes to improve access of the elderly population to needed mental health care. Recognizing that Medicare's restricted coverage of mental health services to those provided by a physician impedes access to care, H.R. 111 proposes Medicare coverage for mental health services provided by psychologists, clinical social workers and psychiatric nurses.

The Mental Health and the Aging Act was originally introduced in the 100th Congress following a series of field hearings on improved access to mental health care by the elderly population. NASW and NFSCSW recommend that the Subcommittee consider H.R. 111's proposed Medicare reforms, including proposed coverage of mental health services, as a beginning to improve the delivery of mental health services to the elderly and disabled populations.

We appreciate the opportunity to express our views to the Subcommittee and look forward to continuing to work with the Subcommittee to improve the delivery of mental health services through the Medicare program.

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